UNLOCKING THE TRUTH

Families' Experiences of the Investigation of Deaths in Custody

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INQUEST
Working for truth, justice and accountability

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Contents

Chapter 1: Introduction

1.1 What the report is about

This is an evidence-based report about bereaved families' experiences of the investigation process and inquest system following deaths in custody. It gives voice to these families and presents their experience in their own words.

We have situated their comments within a description of the procedures families face. We draw attention to the changes that need to be made to ensure that the investigation and inquest system are compliant with human rights standards, respect bereaved people and ensure democratic accountability of state institutions.

By families we mean the broad concept of family that includes partners, parents, siblings, children, guardians, grandparents and others who have had a direct and close relationship with the deceased.

By death in custody we mean death in all forms of state detention: in prison; in young offender institutions; in secure training centres; in immigration detention centres; in police custody and following contact with the police or pursuit; or while detained under the Mental Health Act 1983. The focus of this report is on the circumstances and procedures that surround the investigation of deaths in prison and police custody.

1.2 The purpose of the report

During the writing of this report hundreds of people have died in detention[1] – many in deeply troubling circumstances. The purpose of the report is to document the families' experiences, to inform the government's anticipated reform of coronial law and the operation of the new investigation systems. The report makes explicit what is necessary for the government to achieve their publicised commitment to "an improved service for bereaved people and others who interact with the coroner system [and] more effective coroners' investigations."[2]

The report aims to inform policy makers and practitioners from both official and voluntary organisations. It aims to improve and develop practice of all those who work with bereaved families – coroners, coroner's officers, investigators, counsellors and therapists. It describes both good and bad practice.

It is the second of two reports that form INQUEST's project – *Study of families' experiences of the investigation of deaths that require an inquest* – funded by the Nuffield Foundation. The first, published in November 2003 – *How the inquest systems fails bereaved people* – set out our concerns about the thematic problems with the inquest system irrespective of circumstances of death.

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1. See chapter 2.
2. *Coroner Reform: The Government's Draft Bill,* 2006, p 8.

1.3 What motivated the report

It is clear from our operational work with bereaved people and their advisors that there are widespread problems with the investigation and inquest procedures. We have noted the similarities of experience amongst bereaved people, all of whom have raised shared concerns about aspects of the existing system. Their understandable dissatisfaction stimulated our interest in conducting this focused piece of work.

What no previous study has done is record in detail the experiences of families bereaved by a death in custody; knowledge about this experience is largely undocumented.[3] No comprehensive assessment has been made of the present system: what helps bereaved families and which therefore should be retained or expanded; what they find distressing, or which excludes them, or which causes injustice, and which requires reform or abolition in the new system. However there have been studies and reports about the experience of families following deaths in other controversial circumstances which have informed both our thinking during this report and our work in general.[4]

Having identified this gap in knowledge, INQUEST is uniquely placed to gather information about families' experiences. Families trust us and they are willing to share their experiences in a way that they might not with other researchers. We can also draw upon the combined experience of the staff team, the INQUEST Lawyers Group, and our trustees and advisory board.

The report is underpinned by questionnaires, interviews and casework studies. We have sought the views of families, experienced lawyers who represent them, INQUEST's caseworkers and those working for voluntary organisations providing advice to bereaved people.

We believe the experiences of families and their suggestions about how to improve the system are a valuable resource that should be recognised. This is not just out of human decency and respect for their loss; or to make them feel better by listening to their concerns, although this is important. Families should be heeded because they are the ones who have been directly affected by the policies at issue and so can provide crucial data about where the system is failing and what can be done to improve it.

All the information necessary is already available to make well evidenced suggestions for protocols that could deliver justice and potentially save lives. Action can be taken now: we hope this report will be taken into account by those reforming the inquest system and developing the new investigation processes.

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3. The only recent books written about deaths in custody are *In the Arms of the Law*, 1987 and *Lobbying from Below*, 1995; their primary focus is not families' experiences.
4. *No Last Rights*, 1995; *Beyond Disaster*, 1997.

1.4 Structure of the report

In chapter 2, we present the social and political context in which the significance of these deaths is considered. In chapters 3 to 6 we examine each stage of post-death procedures, following the timeline of families' experience: immediately after the death, the investigation process, the inquest, and after the inquest. We present comments from the families affected and put forward practical suggestions for immediate improvements to the system on their behalf. At the end of each chapter we list the recommendations argued for in the text. In chapter 7 we conclude with key proposals for reform. In appendix A we set out a best practice case study and in appendix B information about methodology.

1.5 Acknowledgements

We are grateful to the Nuffield Foundation for funding this report and for their patience and understanding during the course of the project.

During the writing of this report we have worked with and been supported by a wide range of people. We have drawn on the experience of the INQUEST staff team and Board and particular thanks are due to our senior caseworker Gilly Mundy and caseworker Catherine Hayes. We have discussed the project and received comments from academics, pathologists, lawyers, families, coroners and other voluntary organisations. We thank them for their encouragement and interest.

We are grateful to the lawyers who contributed their views and to the staff from voluntary organisations who we interviewed. We are also indebted to our readers who commented on the final draft and thank lawyers Fiona Borrill, Ruth Bundey, Fiona Murphy and Leslie Thomas and academics Professor Phil Scraton, Professor Joe Sim, and Dr Tony Ward.

None of this would have been possible without the generosity of the families who have shared their experiences with us; for some this was undoubtedly extremely painful. We thank them all. Many of them have chosen to remain anonymous so all quotes in the report are attributed by a description of relationship to the person who died.

Chapter 2: Social and Political Context

2.0 Introduction

This chapter sets families' experiences within the political, recent historical and legal context of deaths in custody. It describes the issues which have emerged in the last 25 years that have shaped public, family and state perceptions and places the family experiences described in chapters three, four, five and six in that context.

INQUEST's work since the early 1980s with families bereaved by deaths in custody revealed serious shortcomings in the mechanisms of legal and democratic accountability and led the organisation to develop a critical analysis of custodial deaths. Until recently, complacency and inaction have characterised the government response, indicating a failure or unwillingness to ensure that systems are in place to prevent further deaths and ensure accountability.

For many years it was difficult for INQUEST and bereaved families to make their voices heard. We were vilified for raising issues that are now accepted as legitimate concerns. Families were marginalised and excluded from debate, but their tenacity and strength was instrumental in drawing national and international attention to the lack of independence in the investigation process, to abuse and neglect by custodians and institutional indifference to the deaths.

During the period covered by this report (2000 – 2005), post-death processes have been subject increasingly to reform. Sustained campaigning by bereaved families and their representatives, and reactions to the Marchioness and Hillsborough disasters, to high profile deaths in custody and the murders of Stephen Lawrence and Zahid Mubarek, contributed to widespread public concern about the investigation and inquest systems and provisions for holding those responsible to account. Reforms and legal cases have modified policy and practice and at the time of writing further changes, in particular to the coroner service, are ongoing.

2.1.1 How many people die in custody?

2,122 people died in prison and police custody between 1995 and 2005. Of these, 802 people died following contact with the police[1] and 1,564 died in prison. See Table 1. An unidentifiable number died in psychiatric and immigration detention.

2.1.2 Who are they?

The monitoring role at INQUEST is one of its key functions: it encourages greater transparency and understanding of the numbers and nature of deaths occurring in custody. The organisation has been at the forefront of ensuring this information has been made available, analysed and placed into the public domain.[2]

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1. Excludes deaths involving road traffic accidents.
2. There is no central collation or publication of figures about deaths of detained psychiatric patients; the same holds for deaths in immigration detention until April 2006.

Attention has been drawn to shared features of deaths within particular groups of people, for example young people in prison, children in detention,[3] women in prison,[4] working class men, black[5] people, or people with mental heath and drug and/or alcohol problems. Despite repeated identification of the same systemic failings at inquests, no fundamental changes have been made to practice, which points to major failings in the investigation and inquest systems.

2.1.3 How do they die?

People die in custody in a broad range of circumstances including:[6]

- in police and prison cells as a result of medical neglect;
- self-inflicted[7] deaths in prison and police cells;
- following the use of force by police and prison officers – CS spray, batons, firearms, body belts, neck holds and other restraint techniques resulting in the inhibition of the respiratory system and asphyxia;
- homicide in prison.

Many of the deaths raise issues of:

- negligence;
- systemic failures to care for the vulnerable;
- institutional violence, racism, sexism and inhumane treatment;
- abuse of rights;
- state and corporate accountability.

2.2 Family perspective

Regardless of the circumstances of death, most bereaved families have negative experiences of post-death procedures at a time of great vulnerability and in circumstances that are outside their previous experience. Families have sought answers and tried to establish the truth but found a lack of accountability and that the systems of investigation and inquest system did not function properly. They have struggled with their own often limited resources and in the face of intense hostility and opposition both for the truth about their relative's death and for changes to the system of investigation. Their needs are reduced to the lowest priority by institutions concerned to protect their policies, practices and procedures.

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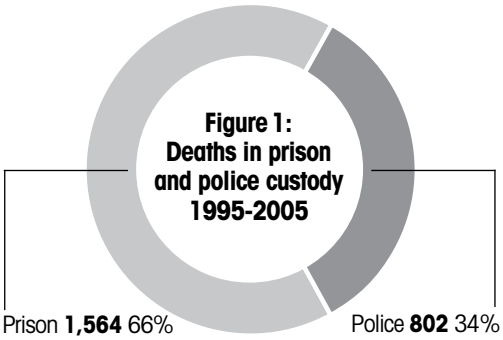
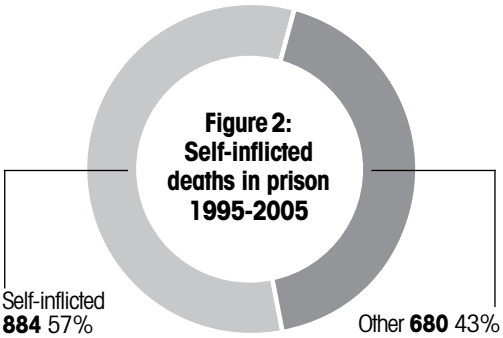
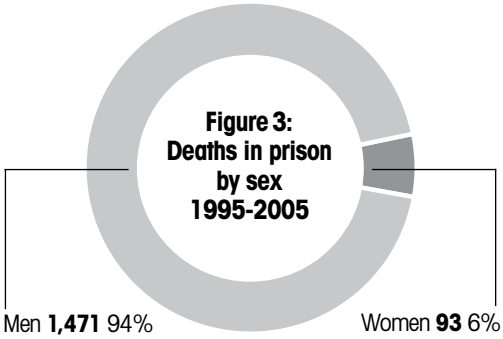
3. See *Why Are Children Dying in Custody?*, 2006.
4. See *Dying on the Inside: Examining Women's Deaths in Prison Custody* (forthcoming).
5. INQUEST uses the word black as a political term to describe people of African, Asian and Caribbean origin.
6. See www.inquest.org.uk for further information.
7. INQUEST uses the term self-inflicted to describe deaths that appear to be directly caused by the actions of the deceased, whether the action causing the death was deliberate or accidental. A hanging or overdose intended as a cry for help will still be classified as self-inflicted should it turn fatal. The difficulty of assessing any form of self-inflicted death in custody is that such deaths usually take place in the context of deep psychological unhappiness. The context in which the death occurred is easily ignored in a system that solely focuses on the outcome.

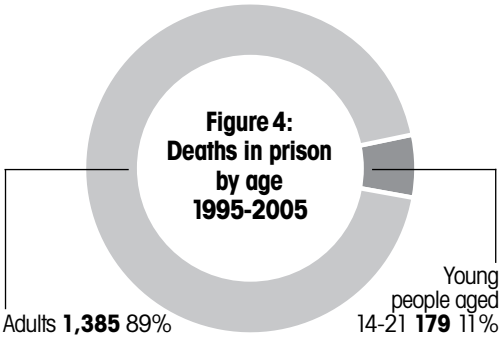
Table 1: Deaths in prison and police custody 1995-2005

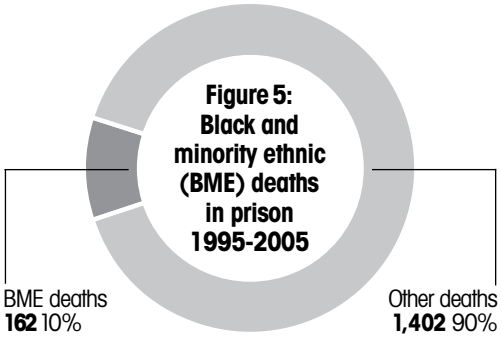
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
Police	52	68	75	77	58	62	64	83	92	88	83	802
Prison	72	119	118	134	146	142	124	153	172	210	174	1564
All	**124**	**187**	**193**	**211**	**204**	**204**	**188**	**236**	**264**	**298**	**257**	**2366**

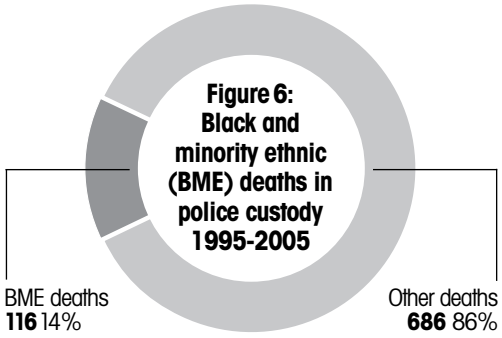












Police – deaths in custody or following contact with the police, in vehicular pursuits or shootings only.
Prison – includes two deaths of children in Secure Training Centres in 2004; in figure 2 other deaths include non-self-inflicted deaths, homicides and deaths during control and restraint procedures.

2.2.1 Perceptions of state violence and racism

Not all deaths in custody arouse public concern, lead to complaints or are seen as particularly controversial – however there have been a significant number of high profile deaths in custody that have raised public and parliamentary disquiet. This has shaped both community and wider public perceptions of the issues raised by deaths in custody and contributed to all bereaved families' suspicions and doubts about the ability of the system to deliver the truth about the circumstances of their relative's death.

Deaths involving the use of force by state agents have been by their nature the most controversial. Their consequent impact on police and community relations in particular has been profound, resulting in a lack of public confidence in the investigation system and considerable public anger, particularly amongst the black and Irish communities about the use of unlawful and excessive force. Monitoring has shown how a disproportionate number of black people, those from minority ethnic groups and those with mental health problems have died in suspicious or controversial circumstances. Cases have revealed a use of violence, security and isolation that is greatly disproportionate to the risks posed, raising questions about the attitudes and assumptions of some state officials and their pre-conceived ideas about the propensity to violence of particular groups of people. Questions also need to be asked about institutional views and responses to particular groups – black communities and the mentally ill – and what contribution they make to shaping and reinforcing individual prejudices. The persistent use of unacceptable levels of restraint is of particular concern. Situations where a young unarmed man, often black, not suspected of any serious offence and in a reasonable state of health is confronted by a group of police/prison officers, dies in an ensuing struggle and yet no-one at an individual or corporate level is found to be at fault, have resulted in untold anger and mistrust directed towards the criminal justice system.

2.2.2 Consequences

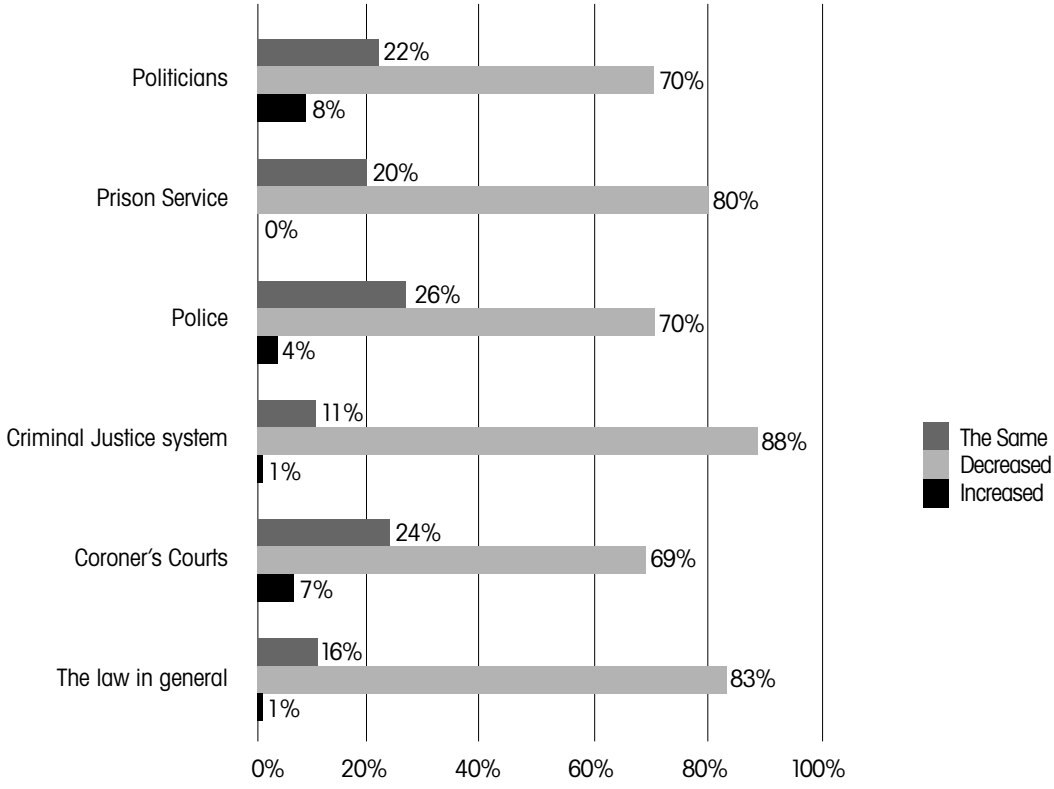
Those bereaved by a death in custody are too often from amongst the poorest and most disenfranchised sectors of society. Because many of the families come from poor, working class and marginalised or discriminated against communities, their perception of deaths in custody may well have been shaped by the experience of others in their community and by their experience of contact with state institutions. In circumstances where the relationship between state and individual is already strained, for example in neighbourhoods of poverty or in communities that are already socially excluded, suspicion of the state's motives feeds a sense of further isolation.

Individuals in these communities see media reports of a death in custody of someone like themselves and empathise not only with the family's dissatisfaction with the way that the death was investigated,

but with their feelings of anger at their sense of exclusion. These communities find the principles of justice that each citizen should be able to place their trust in do not appear to apply to the investigation of the death of a person whose life experience they share, which increases their alienation from the state.

The trust between individual and state is broken down by the perceived lack of accountability, transparency and responsibility following a death in custody. By failing to reform the investigation and inquest system, the state has neglected not only the people most affected, the bereaved family, but the community from which that family comes. The consequence is a dislocation between the state and some of its most vulnerable citizens, a process that causes cynicism and disillusionment as shown in the graph below from our first report.[8]

Figure 7. How would you describe the effect of the inquest on your level of confidence in (the following institutions):



8. *How the inquest system fails bereaved people,* 2003, p4.

2.2.3 Blaming the dead and their families

Deaths in custody often take place in circumstances where the only witnesses are those whose conduct might be called into question. One of the major causes of dissatisfaction with the investigation system has been its lack of independence, impartiality and transparency – it is a process that has until recently been characterised by secrecy and silence. There was no disclosure of documentary evidence to families until voluntary protocols were adopted in 1999; their operation remains problematic. Many investigations were exposed subsequently as inadequate and conclusions about the causes and circumstances of death were dramatically rejected by inquest juries.

The investigations and legal advocacy on behalf of the state have been perceived as attempts to explain away the deaths. As Scraton and Chadwick reported, "speaking ill of the dead" was a "process of categorisation which suggests to some extent the 'violent', the alien, the inadequate, the mentally ill, the hysterical woman, contributed to their own deaths either by their pathological condition or personal choice."[9]

Many of the people who die in custody do not elicit public sympathy. In seeking to condemn and vilify both those who die and their families the state has sought to marginalise and dismiss alternative accounts of the circumstances of the deaths and neutralise concerns. The dead and their families are blamed, which has allowed a long term institutional and governmental denial of responsibility. In refusing to acknowledge the systemic features of the circumstances of the deaths, the state seeks to deny the problem by focusing on "problem" or "dysfunctional" families and the deceased's "criminal" or "anti social" behaviour.

Misinformation has been a feature of many contentious deaths in custody: there have been concerted attempts by the authorities to tarnish the reputation of the deceased in order to deflect attention away from official incompetence or wrongdoing. This is a common institutional response to many contentious deaths in custody which seeks to deflect blame from state agents. These attempts to demonise the person who has died and build up a negative reputation creates the idea of an "undeserving" victim. Many families have described how they felt that instead of the death of their loved one being investigated it was their private life and that of their relative that was subjected to the most scrutiny.

This phenomenon has been documented for example in the cases of Richard O'Brien (1994), Shiji Lapite (1994), Roger Sylvester (1999), Harry Stanley (1999) and Mikey Powell (2003)[10] and most recently following the shooting by police of Jean Charles de Menezes (2005).[11]

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9. *In the Arms of the Law*, 1987, p223.
10. 'We cannot take them at their word – "police sources" routinely vilify victims and excuse police actions', 2005; INQUEST case briefings www.inquest.org.uk.
11. *Fatal Shootings by police and the death of Jean Charles de Menezes*, 2006.

As a consequence these families have been excluded from debates on victims' rights and frequently feel as if they are treated as criminals rather than victims and that they and their relatives are forgotten or considered undeserving of sympathy and support. The state cannot justify its unequal treatment of bereaved people due to the nature of the deceased's ethnicity, class or status. This creates categories of the deserving and undeserving bereaved.

2.2.4 Failure to prosecute

INQUEST's monitoring has shown how the state uses the inquest rather than criminal prosecution and trial for the public examination of deaths in custody. It is extremely rare for there to be a prosecution after a death in custody even where there has been an inquest verdict of unlawful killing.[12]

Despite a pattern of cases where inquest juries have rejected the official version of events and found overwhelming evidence of unlawful and excessive use of force or gross neglect, no police or prison officer or nurse has been held responsible, either at an individual or senior management level, for institutional and systemic failures to improve training and other policies. Since 1990 unlawful killing verdicts have been returned in ten death in custody cases, none of which has resulted in a successful prosecution. Of those cases, eight were black men and the two others were Irish and Scottish. The verdict of unlawful killing can only be returned on the criminal standard of proof where a jury is sure beyond reasonable doubt that the death was the result of gross negligence manslaughter or murder. See Table 2.

Our monitoring has revealed an institutional unwillingness to approach these deaths as potential homicides or manslaughter, which affects the whole process from the investigation carried out by the police (who may not even define the place of death as a crime scene) through to the considerations by the Crown Prosecution Service. This encourages a culture of impunity and sends a clear message to police and prison officers and other detaining agents that when deaths occur as a result of their acts or omissions they will not be called to account. Through this process the perception is created that state agents are above the law. This is one of the most contentious issues in relation to the approach of the criminal justice system to all deaths in custody.

2.2.5 Families engage with the process and improve it

For too long bereaved families were marginalised and seen as less deserving victims or not even as victims at all. Many of the advances that have been made are primarily as a result of the struggles of families themselves who have demanded a voice alongside INQUEST and community based organisations. Families have campaigned in the

12. *Response to consultation paper on Attorney General's review of the role and practices of the CPS in cases of deaths in custody,* 2002.

Table 2. Unlawful killing verdicts 1990-2005

Year[13]	Name	Type	Prosecution	Inquest Verdict	Ethnicity
2004	Harry Stanley	Police Shooting	No	Unlawful killing verdict returned at second inquest; overturned at judicial review in May 2005	UK White
2003	Roger Sylvester	Police Custody	No	Unlawful killing; quashed on a technicality	UK Black
2000	Christopher Alder	Police Custody	Yes – 5 officers charged with manslaughter – trial collapsed 2002	Unlawful killing	UK Black
1998	Alton Manning	Prison	No	Unlawful killing	Black Caribbean
1997	Ibrahima Sey	Police Custody	No	Unlawful killing	Black African
1996	Shiji Lapite	Police Custody	No	Unlawful killing	Black African
1995	Richard O'Brien	Police Custody	Yes – acquitted at trial in 1999	Unlawful killing	Irish White
1993	Leon Patterson	Police Custody	No	Unlawful killing; quashed and new inquest held in 1996. Verdict: "misadventure contributed to by neglect"	UK Black
1993	Omasase Lumumba	Prison	No	Unlawful killing	Black African
1991	Oliver Pryce	Police Custody	No	Unlawful killing	UK Black

face of legal, media, state and political misinformation and hostility: lack of funding; lack of independent scrutiny; and claims that families are manipulated by others.

Individual family campaigns, far too numerous to name here, have been key to this work. The coalition of families who work together in the United Families and Friends Campaign have been tireless in taking their message to the Prime Minister's door every year despite being ignored.[14] The film *Injustice*, which was released controversially in 2001 as the Police Federation tried to have it banned, brought the families' struggles to a wider international audience.

INQUEST continues to work alongside families to bring the issues into the public and political arena and challenge official versions of the truth. As an independent voice it provides a critical overview of the issues arising from deaths in custody, the treatment and care of people in a range of state institutions and how those charged with their care are held accountable or not as the case may be. INQUEST adopted "a theoretical and political perspective that focussed on issues of power

13. Refers to the year the verdict was returned.
14. UFFC Annual Remembrance Procession in October each year from 1999.

and powerlessness" and "ensured that a more challenging and more critical series of questions began to be asked about deaths in custody."[15]

2.3 What has changed recently?

1. The European Convention on Human Rights and the Human Rights Act 1998, together with related case law, have also contributed significantly to the drive for change and modified the framework in which deaths in custody are investigated.
2. In June 2003 the Home Office's Fundamental Review of Death Certification and Coroner Services reported, offering 123 recommendations for change covering organisation, resources, procedure, verdicts and family rights.[16]
3. The Independent Police Complaints Commission took over the investigation of deaths in police custody in April 2004 from the much criticised and discredited Police Complaints Authority.
4. Investigations into prison deaths passed from the Prison Service to the Prisons and Probation Ombudsman in April 2004.
5. The parliamentary Joint Committee on Human Rights (JCHR) published its report *Deaths in Custody* in December 2004. The report expressed serious concern about the numbers of such deaths, highlighting "someone is either killed, kills themselves or dies in otherwise questionable circumstances – every other day. That – quite frankly – is shocking".[17]
6. In June 2006 the government's draft Coroner Reform Bill was published with three main aims: an improved service for bereaved people and others who interact with the coroner system; the introduction of national leadership and improvements to enhance the local nature of the scheme; more effective coroners' investigations.[18]

2.3.1 Legal developments and human rights

The most significant recent development in coronial law has been the implementation in 2000 of the Human Rights Act 1998 and the direct incorporation of article 2 of the European Convention on Human Rights (ECHR), the 'Right to Life', into domestic law. This is understood to be the most fundamental of human rights. Article 2(1) provides that a person's right to life "shall be protected by law"[19] and the state is required to take steps to safeguard the lives of those within its jurisdiction. More specifically, this right has also been identified as extending to taking positive steps to prevent self-inflicted deaths in penal custody.

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15. 'Campaigning For and Campaigning Against Prisons: Excavating and Re-affirming the Case for Prison Abolition', forthcoming.
16. *The Report of a Fundamental Review: Death Certification and Investigation in England, Wales and Northern Ireland*, 2003.
17. *Deaths in Custody: Third Report of Session 2004-05 Vol I*, 2004 para 42, p17.
18. *Coroner Reform: The Government's Draft Bill*, 2006, p8.
19. Human Rights Act 1998, Chapter 42.

Alongside the incorporation of article 2, two significant House of Lords judgments (*Amin*[20] and *Middleton* and *Sacker*[21]) have changed procedure in Coroners Courts.

2.3.2 Amin

The decision of the House of Lords in the *Amin* case established consistent minimum standards for the state's duty to investigate deaths in custody.[22] The Lords ruled that whichever form the investigation takes, there are minimum standards that must be met as set out in Jordan v UK.[23] The Court concluded that there were five essential requirements of the investigatory obligation:

- independence;
- effectiveness;
- promptness and reasonable expedition;
- public scrutiny;
- accessibility to the family of the deceased.

The lack of an investigation which embodies the requisite qualities will in and of itself constitute a violation of article 2. The Court ruled that such requirements apply with at least equal force to a 'state neglect' or omission case as to a state 'lethal hands' case.

Many of INQUEST's concerns about the inquest process were put forward for the family at the hearing including: inconsistency of disclosure of evidence to the family despite the voluntary protocols[24]; inconsistency of funding; the narrow boundaries to the jury's findings; and coroners' current restrictions upon system neglect. The *Amin* judgment recognised these concerns as legitimate.

There is now strong recognition of the need for more effective investigation than can be provided currently by inquests. The issues raised about individual and system neglect in the judgment, although uncommon, are sadly not unique.

As the judgment noted "while any deliberate killing by state agents is bound to arouse very grave disquiet, such an event is likely to be rare and the state's main task is to establish the facts and prosecute the culprits; a systemic failure to protect the lives of persons detained may well call for even more anxious consideration and raise even more intractable problems."[25]

Lord Bingham recognised preventing similar deaths as one of main purposes of the investigation and thereby humanely connected the needs of the bereaved as evidenced in this report with the duties of the state to investigate adequately.[26]

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20. *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51.
21. *R v. HM Coroner for West Somerset and others ex parte Middleton* [2004] UKHL 10 and *R v. HM Coroner for West Yorkshire ex parte Sacker* [2004] UKHL 11.
22. See 'Amin: The Legal Significance', 2004.
23. *Jordan and ors v. UK* [2001] 37 EHRR 52.
24. See 2.2 above and chapter four 4.4.2.
25. *Amin op cit.*, para 21.
26. 'Amin: The Legal Significance' *op cit.*

2.3.3 Middleton and Sacker

In the House of Lords cases of *Middleton and Sacker* (11 March 2004), their Lordships affirmed that article 2 of the ECHR required there to be an effective official investigation into a death involving the state. The two cases concerned prisoners who had hanged themselves in circumstances where prison officers and health care staff might have done more to prevent the deaths.

The critical function of a coroner's inquest is to determine how a person came by their death. The word 'how', as used in inquest law, is contained in section 11(5)(b)(ii) of the Coroners Act 1988 and rule 36(1)(b) of the Coroners Rules 1984.

Before *Middleton*, the case of *Jamieson*[27] meant that 'how' should be interpreted as 'by what means' and not 'in what circumstances'. This narrowed the circumstances in which state responsibility for a death in custody could be reflected in the conclusions of a jury. It also required inquest juries to ensure that in any acts or omissions surrounding the death there was a clear and direct causal link with the death itself, as opposed to being satisfied that they amounted to a more than minimal cause – a test that operates routinely in other areas of civil and criminal law.

As a result of *Middleton and Sacker*, the word 'how' is interpreted as 'by what means and in what circumstances'. Inquest juries have more opportunity to draw attention to any failings through the use of narrative verdicts, or in answers to questions put to them on factual matters by the coroner.[28]

The *Middleton* ruling signifies a major breakthrough for inquest law. The essence of these decisions is that they require an inquest to return verdicts which properly reflect:

- whether a person deliberately or accidentally takes their own life in part because the dangers of their doing so were not recognised by the prison authorities;
- whether appropriate precautions could have been taken to prevent the death.

These two judgments have had a positive effect on the inquest system and we hope this will be reflected in the proposed reforms of the system. However, they have also demonstrated how under-resourced and ill-equipped the current system is to meet the requirements of the law.

The beneficial impact of the *Middleton* judgment on the conduct of inquests is clear – in particular we note the increasing number of detailed narrative verdicts delivered. The judgment also demonstrates the important contribution that members of the INQUEST Lawyers

27. *R v. North Humberside Coroner ex parte Jamieson* [1995] QB 1.
28. We address the practical application of this and its implications in Chapter 5.

Group[29] play in ensuring that contentious deaths are properly scrutinised and that there is the opportunity for juries to comment in detail on the evidence which they have heard about any systemic and individual failings that contributed to the death. However, there are still too many deaths where the deceased has no representative present and where the death is insufficiently scrutinised.

2.4 Concluding remarks

The number of custodial deaths remains far too high and the cases reveal a horrendous catalogue of failings in the treatment and care of vulnerable people in custody or otherwise dependent on others for their care. Many cases raise questions about excessive and inappropriate use of custody for some of the most vulnerable people in society; they also highlight failures to fulfil the state's duty to protect life. Inquests repeatedly identify the failure to implement existing guidelines on the care of 'at risk' detainees.

It is clear from INQUEST's monitoring and analysis of deaths in custody that understanding why these deaths occur requires an examination of their broader social and political context. No discussion of self inflicted deaths in prison can ignore the regimes and conditions operating in prisons, criminal justice policies that imprison the mentally ill and vulnerable or the institutional culture of violence and racism that exists there.

Recent cases documented in *Inquest Law*[30] question the ability of the state to fulfil its article 2 duty to protect the right to life of those in its care and prevent inhuman and degrading treatment. The increasing number of narrative verdicts returned in such cases is a welcome development that has the potential to make the process more meaningful for all involved, but for this to occur it is vital that a reformed system ensures that findings and recommendations are collated and published, that their implementation is monitored and a publicly accessible database is created (see chapters 5 and 7).

Deaths in custody continue to indicate a systemic failure to learn lessons: to review, revise and implement policies, instigate new training, or share and disseminate information and guidance across different state agencies. They also demonstrate the abuses of power of institutions over the powerless indicating cultures of violence, neglect, racism and indifference which continue because of inadequate individual and corporate accountability. We present bereaved families' experiences in this context in the next four chapters.

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29. The INQUEST Lawyers Group is a panel of lawyers organised by INQUEST across England and Wales that provides preparation and legal representation at coroners' inquests for bereaved people; promotes and develops knowledge and expertise in the law and practice of inquests; provides training; and acts as a forum for the exchange of ideas and experience. INQUEST publishes the journal *Inquest Law* which informs practitioners about recent legal and policy developments relating to the inquest system and the investigation of sudden deaths.

30. *Inquest Law*, Issue 11 March 2006.

Chapter 3: Immediately After the Death

"A death in custody, once it has occurred, requires respect for the rights of the family of the person who has died. Several of the families [we met during this inquiry] had been informed of a death in ways that were highly insensitive, and several had been given insufficient information about what had happened, or had been obstructed in their attempts to obtain information." (Parliamentary Joint Committee on Human Rights)[1]

> 'There should be specially trained people to talk to the bereaved and to be there from day one to help the people who have just lost a loved one and to give advice.' [Family of a man who died in prison]

> 'Families should be given an information pack explaining their rights and the importance of immediate legal advice.' [Family of a child who died in a young offender institution]

3.0 Introduction

Families bereaved by a death in custody are dealing with a traumatic event and with the fact that the death has occurred in detention or at the hands of state officials. This adds further distressing emotional and practical dimensions to their experience.

This chapter is the first of four that set out the evidence from bereaved families. We describe briefly what happens immediately after a death in detention from their perspective, the relevant human rights standards surrounding their involvement and what happens to the body of the deceased person. We discuss how families are supposed to be treated, their actual experiences and suggestions for change in the following areas:

- Notification of the death
- Access to the body
- Post mortem examinations
- Provision of information and support
  a. Role of the Coroners Court
  b. Role of the voluntary sector
  c. Role of the institutions of detention and investigation bodies

Throughout the evidence-based chapters, we make recommendations and present families' suggestions for changes in practice. We highlight the particular issues that need to be addressed to ensure the service does not discriminate against those from minority ethnic communities, bearing in mind the social and political context outlined in chapter 2. We show how all agencies involved in the processes that follow a death in custody have a crucial role to play in supporting bereaved people through provision of information and appropriate referral to specialist support. We then demonstrate how systems are failing through basic lack of provision and poor implementation of existing protocols.

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1. *Deaths in Custody: Third Report of Session 2004-05 Vol I,* 2004, paras 286-7 p81.

3.1 Human rights standards

The criteria for an effective investigation under article 2 of the Human Rights Act 1998 were summarised in *Jordan v UK*[2] and include family participation. The inquest together with the investigation into the death forms the article 2 compliant investigation. The way families are treated by those who inform them of the death and provide information about the ensuing investigations and the inquest process affects their ability to participate in the process. Failures of the system to engage appropriately with the bereaved are open to legal challenge.

> 'Bereaved next-of-kin need to be (i) treated with respect and sensitivity, (ii) kept fully informed, (iii) enabled to make informed choices, (iv) central to the procedures and investigation that follow a death in custody.' [Family of a woman who died in prison]

> 'Families should receive support from the prison, if the family requires it, for at least 6 – 9 months after something like this happens. Not be told by the Governor and a few members of staff about the tragedy one day, have their loved one's belongings brought back to their home within two days of the tragedy, and then forgotten about like this family has. Left to try to get on, pick up the pieces, and carry on as normal. Families don't and can't do that, life is not like that…this person, no matter how worthless the prison believed he or she to be, was someone the family loved.' [Family of a man who died in prison]

All deaths that occur in detention should be reported to the coroner and an inquest held.[3] In the vast majority of these cases the inquest will be held with a jury.[4] Most people know nothing about inquests. Bereaved people have to negotiate a maze of different official bodies and processes at a time when they are extremely vulnerable. The inadequacy of the existing services and the complex relationships between the official bodies involved in the aftermath of the death currently undermines family involvement.

This is why families need legal representation to enable their effective participation: to instruct a pathologist; to explain complex legal procedures and rights; to prepare a statement for the investigation bodies; to formulate questions for the investigation to address; to request documents to be disclosed; to interpret the findings of the draft report to families; to represent the family at the inquest; and to follow up responses to rule 43 reports that allow coroners to recommend action at the conclusion of an inquest. All these points are covered in the following chapters.

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2. *Jordan and others v UK*, [2001] 37 EHRR 52.
3. Coroners Act 1988 Section 8 (1).
4. Coroners Act 1988 Section 8 (3). The Act is silent on deaths in psychiatric detention, immigration detention and Secure Training Centres. We have argued in numerous submissions that the Act should be amended to cover these cases.

3.2 What happens after a death in detention

When someone dies in custody, within a closed institution or whilst in contact with state agents, the body will be under the jurisdiction of the coroner and a post mortem will be ordered. The inquest will be opened for formal identification of the body and then adjourned to a later date for the full hearing once the investigations have been completed. An interim death certificate is issued to allow the funeral to go ahead. It may then be months but far more likely years before the inquest hearing is held.

Most people are unaware that because of the coroner's jurisdiction, the body of their relative does not 'belong' to them, but is under the control of the coroner and that their rights are therefore limited. At this stage it is important that families are given the following information:

- where the body is;
- how and when they can have access to it;
- information about post mortem procedures including organ retention;
- how to access legal advice and practical and emotional support;
- information about what will happen next.

3.2.1 Notification of the Death

"I note the insensitivity and rudeness with which people are given news of their relative's death which is utterly inexcusable. There are not many social skills required to do something more with dignity." (Ian MacDonald QC)[5]

"In a number of cases we were told of, parents were informed of the death of a son by telephone … We were concerned … that in the immediate aftermath of a death, families are not always treated with the respect and consideration they deserve." (Parliamentary Joint Committee on Human Rights)[6]

> 'At about 2am two very young police officers came to my home and told me that my son had been found dead (I found out later he had been pronounced dead at about 3pm). They knew no other details, including how the death had occurred or where. They gave me a scrap of paper with a number scrawled on it and told me to ring it during office hours for more information. I spent the longest night of my life before phoning the number which was incorrect. I can't remember what time I discovered that my son had hung himself in prison.' [Family of a young man who died in prison]

Prison service and police protocols have changed during the period covered by this report and recognise the need for better practice in

5. Speaking at the UFFC Tribunal, Conway Hall, July 2001.
6. *Deaths in Custody: Third Report of Session 2004-05 Vol I, ibid.*

relation to informing the family of the death. However there is still no uniformity of approach despite the important impact this has on the family's ability to engage with the subsequent investigation and inquest.

Responsibility for informing the family and other relevant agencies including the Coroners Court about a death in prison rests with the governor of the prison or in the case of a contracted-out prison, the director. In practice, notification can take the form of the family being visited by staff from the prison (if local) or by police officers or staff from the prison nearest to the family home. Sometimes the prison governor or other members of the staff team, for example the chaplain, will inform the family. It is unclear whether all personnel involved are required to be trained to agreed basic standards or to operate within clearly understood protocols. On occasions prison personnel baulk at conveying the news, fearing apparently for their own safety.

After a death in police custody the family will be informed by police officers. Some are informed by officers from the nearest police station to the family home who may or may not be from the same station or police force involved in the death. In some cases families are assigned a Family Liaison Officer (see chapter 4). In recent cases (after April 2004) notifiers may be accompanied by someone from the IPCC, either a Commissioner, investigator or Family Liaison Manager.

A minority of families reported that they had been treated well, saying that they felt that the person who informed them of the death had been broadly sympathetic and understanding.

> 'The prison governors were very good because they: answered questions, arranged a special visit for another brother who was also in prison, allowed the family to gather as a unit, gave privacy and plenty of time, allowed the brother that was sharing the cell of the deceased to break the news rather than an official.' [Family of a man who died in prison]

It is clear that it is possible to notify families of a death thoughtfully and compassionately. But whether this is achieved is currently entirely dependent on the approach of individuals rather than staff being supported and trained to carry out a complex and demanding task within an agreed framework.

60% of families surveyed were dissatisfied with how they were given news of the death. The most frequently cited complaints were lack of information, misinformation, the inappropriate manner of notification and delay – so that the news had already broken through other channels.

> '[They were] insensitive and thoughtless. They made the decision of who should be told and who should not be told.' [Family of a woman who died in prison]

> 'Shocking. [They] didn't ask if I was sitting down or anything.' [Family of a young woman who died in prison]

Family members have an exceptionally clear memory of the minutiae of the moment they were told that their relative had died. They remember if the news was given by telephone instead of in person, whether they were asked if they were alone or had company, whether they were sitting down. They recall if they were asked who else should be informed, when and by whom. They remember how long the person who broke the news remained with them and whether they were anxious to leave.

But many families can empathise with the need for proper training and support for those who break news of a death.

'Properly trained personnel [should] deliver the bad news.' [Family of a man who died in prison]

'Just told my daughter was dead by the police at 2am. They were obviously upset having to tell me the news.' [Family of a woman who died in prison]

'Police should have extra training in this type of work particularly with regard to attitude and delivery.' [Family of a woman who died in police custody]

Casework example

The father of young man who died in prison in April 2003 was deeply distressed by the way he was notified. He was telephoned at work and told over the phone. He had to go to a stairwell as there was no privacy where he worked. Reports of the death were already on the local radio before he knew though the name was not mentioned. The prison governor was not in contact with him.

Everyone who may inform a family of a death in custody should receive mandatory basic training so they can notify relatives with accuracy, clarity and sensitivity. The staff responsible should be properly and professionally supported and their training should be updated at regular intervals. There should be agreed protocols and standards across the police and Prison Service. Where possible families should be told face to face about a death and steps should be taken to ensure that the relative has appropriate support mechanisms available.

3.2.2 How the news impacts on families

3.2.2 a Immediate support

Many families report how they felt abandoned and left feeling bewildered once they had been told about the death. The absence of human contact and compassion contributed to the distress that the family experienced both at the time the news was given and afterwards.

> 'We believe police people assisting people who have just lost a loved one should have adequate bereavement training or give us the names and numbers for help, not tell you and walk away. We had to phone around doing it all after just being told our daughter aged 25 had committed suicide. You need help at [such] a time in your life and it's NOT THERE.' [Family of a woman who died in prison]

> '…Next day, the prison offered to send a chaplain but we declined. We were given INQUEST's number then left alone and had no further support from the prison or social services and little help from the police. Prison staff are offered support in these circumstances but families are totally disregarded.' [Family of a child who died in a young offender institution]

> '[We need] more information about our rights, and this would need to be provided in writing to enable the bereaved to take it in. Emotions are running riot at the time and more consideration needs to be given to next of kin'. [Family of a man who died in prison]

After a sudden bereavement it is difficult to absorb new information. All information given orally should be duplicated in writing. A direct number and contact name that can be reached out of hours should be left for the family. At the time of notification the family should be offered the opportunity to meet the relevant senior official and to visit the scene of the death if they wish.

As the then Chief Inspector of Prisons, now Lord David Ramsbotham, said in 1999: "It would be good practice…to nominate a member of staff to act as a continuing personal link between the family and the establishment."[7]

3.2.2 b Accuracy of Information

For those breaking the news there may be an understandable temptation to reassure and comfort the family and in doing so inadvertently give misleading information. When the family hear later about the circumstances of the death they will compare that information with what they were told initially; any differences between versions can create suspicion and distress. Only accurate information should be given at the initial meeting: this will be the information that families hold onto until the outcome of the investigation. Inaccuracies lead to mistrust. The information should also be provided in writing so that investigators or those involved in subsequent family liaison are alerted if the family have been given incomplete or inaccurate information.

> '[The] information given at the time was inaccurate and conflicted with that given subsequently.' [Family of a man who died in prison]

> 'Full and frank information [should be] given to the next of kin immediately.' [Family of a man who died in prison]

However painful; it is false comfort to withhold distressing information that will subsequently come to light during the investigation and inquest process.

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7. *Suicide is Everyone's Concern – A Thematic Review,* 1999 para 4.12, p32.

3.2.2 c Families as carers

Some family members reported how they were either alone with young children or elderly relatives when they were told about the death. The difficulty of reacting to shocking news whilst being the sole carer of other dependents led them to ask that consideration be given to the impact of the news on carers' ability to function in the immediate aftermath.

> 'Police [should be] trained to give news of the death in a very sensitive way and to take care of the children while the parents deal with the shock of the death.' [Family of a young man who died in prison]

> '[I was] informed by a lone local police officer. He was calm, kind but obviously just did not know how to deal with two hysterical, deeply distressed, vomiting women and a shocked disabled teenage boy. The officer should not have been asked to break such news unaccompanied.' [Family of a child who died in a young offender institution]

3.2.2 d Timing of notification and media involvement

For many families, finding out that they were not aware of the death of their relative for hours after it happened is particularly painful.

> 'He died in the morning and we were not informed until three in the afternoon.' [Family of a man who died in prison]

> 'Families should be informed sooner of the death.' [Family of a man who died following contact with police]

On a number of occasions, families have found out about a death from local TV and radio news before they have been notified officially.

> 'We first heard via teletext. Then a family friend telephoned to confirm my brother had been killed by the police. We had to ring around to find anything out, starting with our local police station then trying to get information from the police. We were treated disgracefully. [Family of a man shot dead by police]

> 'Initial treatment appalling – no mention of information [having been] released to the press/TV etc'. [Family of a man who died in prison]

To add to the suspicions of bereaved families, there is a long and controversial history of false, misleading or inaccurate information about people who have died in custody being put into the public domain (see chapter 2). In particular, the concerns, fears and suspicions of people from black and minority ethnic communities about deaths in custody should be understood by those breaking the news to ensure this first contact is handled professionally and sensitively.

In all cases, it is crucial that information provided upon notification is accurate and that there should be a transparent process for its release. It should be a priority to notify the family as soon as possible after the death and no information should be released to the media until the family has been informed.

The parliamentary Joint Committee on Human Rights stated: "All institutions of detention should develop and implement procedures to inform family members of a death promptly and sensitively, to provide them with appropriate support … to provide them, promptly, with information on the circumstances of the death and seek agreement with the family on procedures to be used for the return or disposal of the possessions and personal effects of the deceased. Staff members should be trained in effective liaison with families in these circumstances. Contact details of the next-of-kin of detainees should be kept as comprehensively as possible to ensure that they can be informed in as sensitive way as possible. Wherever possible, staff should visit the family to inform them in person of the death."[8]

In response to this recommendation, the government agreed in March 2005 "that it is important to provide families bereaved by a death in custody with prompt, accurate information and with sensitive support and assistance for as long as is necessary."[9]

Recognition of how crucial these early stages are has not yet been translated into any co-ordinated practice and policy initiatives. There are three separate issues: first is appropriate, timely, sensitive, accurate notification, with support for people to take in the news; second is the provision of information about what will happen next and signposting to named official channels of information; and third is signposting to independent legal advice and emotional and practical support which enables families to participate in the process.

> 'I reiterate that there needs to be more immediate knowledge of who and what is available for people who find themselves in our position and awareness needs to be raised within the judicial system of what is available to present to us.' [Family of a man who died in prison]

Government and state institutions have a limited understanding of the intricate support needs of families and the lack of support currently available.[10] Neither the complexity of the problem nor the

Casework examples

Even though Mr X had clear identification and contact details on him (including his passport and his bankbook) and the death occurred only one hundred yards from his home, his widow was not informed about his death for more than eighteen hours. His body was left lying uncovered in the street for several hours and the blood on the ground from his injuries was not cleaned up. The failure to inform the family meant they were unable to instruct their own legal and medical representatives to be present when the first post mortem took place the next morning. Once located by the police, the family was given no information about where they could go for advice and support.

The widow of a man who died in prison found out that other people who lived on the same estate had known about her husband's death before she had been notified.

8. *Deaths in Custody: Third Report of Session 2004-05*, 2004, para 287, pp81-82.
9. *Government Response to the Third Report from the Committee: Deaths in Custody: Eleventh Report of Session 2004-2005*, 2005, para 287, p47.
10. There is no ongoing support and assistance other than that provided by the voluntary sector, family support groups and family lawyers.

creativity needed to solve it has been acknowledged. The existing service has evolved piecemeal; a continuation of this approach is unlikely to suffice. In the short term, co-ordinating an approach to notification and provision of information involving multi-disciplinary groups could be addressed in the Forum for Preventing Deaths in Custody.[11]

3.2.3 Access to the body

After the family have been informed about the death their most immediate concerns are usually about the location of the body and when they can see their relative. For very many families physical access to the body is exceptionally important, irrespective of their religious faith or no faith.

Dame Janet Smith noted in the report of the Shipman Inquiry that, "the reasonable expectations of all should be met, whether they are Muslim, Jew, Christian, atheist or of any other faith or persuasion."[12]

Tom Luce suggested in his fundamental review of the coroner service that there should be, "an obligation on the coroner's office to make contact as quickly as possible with the nearest relative of the person who has died and inform them of the location of the body, the arrangements for viewing it, any autopsy or other investigation proposed, the likely timescale and details of the investigation and the probable release timing of the body."[13]

Once a body is under the jurisdiction of the coroner it is held at either the public mortuary or hospital mortuary. Each location has its own practice in relation to family access to the body. A number of families were not even told the location of their loved one's body.

> 'I was not told where the body was. I was offered no access to her, it seemed to be taken for granted I would not want to be with her and that my only concerns would be to arrange a funeral as quickly as the coroner allowed. None of my needs were ever considered, not religious, not medical, not emotional.' [Family of a woman who died in police custody]

> 'I called the prison shortly after [the officer] left us and it may be that the governor told me then. I then called CID who tried to discourage us from going to the hospital. We insisted and met CID officers and then transferred to the hospital to see my son. The officers appeared more interested in telling me not to touch my child than in assisting us to cope, we were interrupted while with my son and then expected to chat at the hospital entrance.' [Family of a child who died in a young offender institution]

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11. A cross agency group set up in February 2006 with the following terms of reference: "The Forum exists to learn lessons and effect change to prevent deaths in custody." It involves relevant state and independent officials and agencies. www.preventingcustodydeaths.org uk
12. *Death Certification and the Investigation of Deaths by Coroners* 2003, para 12.42, p280.
13. *The Report of a Fundamental Review: Death Certification and Investigation in England, Wales and Northern Ireland* 2003, chapter 12, para 18, p144.

Two thirds of the families surveyed reported that access to the body was inadequate. Some were advised not to view the body which left them with unresolved suspicions and feelings of guilt and loss.

> 'We were advised not to go and view our son's body. We were never given any reason for this, but we took the advice, as we didn't know what to expect. We often wonder if some of his organs had been removed.'[14]

Some found it difficult to travel to the location and others reported feeling inhibited as they were watched by officials.

> 'We had to arrange our own transport. We had no help from any outside agency. We were all vetted before we were allowed to see our loved one and also watched by a policewoman within close proximity' [Family of a man shot dead by police]

> 'Once we had witnessed his demise, no further access was permitted including that of my [the victim's] mother, who was in transit from Jamaica at the time.' [Family of a man who died following contact with police]

> 'Transport to the deceased should be arranged at a time to suit the family.' [Family of a child who died in a young offender institution]

Difference in the approach taken by staff at the mortuary impacts on the experiences of families, as do the variations in the quality of the facilities available.

> 'I was not able to get to him because he was behind glass in another room. I did not get his body until a month after, and then only for four hours. I was unable to embalm him as the body was deteriorating.' [Family of a man shot dead by police]

> 'I was upset by the way the body was presented. He was trussed up so that I couldn't hold his hands and I was only allowed to visit once.' [Family of a man who died following contact with police]

> 'I was not given adequate access and only viewed the body through a screen.' [Family of a man who died following contact with police]

Others described their disquiet about not being able to see the body before the post mortem.

> 'I felt I should have seen him before the post mortem.' [Family of a man who died in prison]

> 'We were refused access to view his body on the date of death although we requested it, [and] only got to see my deceased husband four days later, after the post-mortem' [Family of a man who died in prison]

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14. Quoted in *How the inquest system fails bereaved people,* 2002, p8.

> 'I was told initially that my daughter's body was at the hospital. I was not given adequate access to the body – I was not given the opportunity to see her until after she had been dead for two days. She had been moved to a different hospital (without me being informed) and the post mortem had already taken place (without me being notified of day, time and place).' [Family of a woman who died in prison]

Over a third of the respondents did not feel that their religious and cultural needs were respected. This may indicate that those responsible for arranging the viewing of the body are not being trained appropriately, if at all, to be aware of the different religious and cultural needs and practices within the community they serve.

> 'Cultural/religious needs were not mentioned despite my husband's obvious ethnic minority status.' [Family of a man who died in prison]

> 'The family should have the opportunity to identify the body of the deceased.' [Family of a woman who died in prison]

These experiences exemplify how the state assumes ownership[15] of the body of the deceased over and above the family. In deaths in detention this has additional significance as physical contact between the deceased and their family may not have happened for some time.

Those working within the coroner service need to understand how shocking it is for bereaved people to discover their relative's body does not 'belong' to them and show sensitivity in explaining the situation. Bereaved families should be able to view and touch the body and say goodbye as soon as they wish and particularly before the post mortem examination. It is often argued that this is not possible for legal reasons but we suggest that unless the death is highly controversial and potentially subject to a homicide investigation then the presumption should be to grant access. Even in deaths which are the subject of a homicide investigation (and therefore the need to preserve continuity of evidence is crucial) the family should be allowed access to the body and the integrity of evidence can be protected by the presence of the investigating police officer. Officials should also be aware that different religions and cultures have post death rituals that will be interrupted by failure to give physical access to the body. Whilst most faiths accept this restriction, coroner's officers must understand the potential for distress to the family.

3.2.4 Post mortem examinations

There is always a post mortem examination following a death in custody carried out on behalf of the coroner. Families have no choice about whether it takes place – they do not have to give their consent.

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15. The issue of ownership of human bodies is one that has been the subject of much legal, ethical and philosophical debate.

Families can ask the coroner that a second post mortem be carried out on their behalf (see 3.2.4c). Where a death has occurred in detention and where there is suspicion or doubt about its cause, a second post mortem can provide crucial information. Where the events surrounding the death are a matter of dispute, and there is suspicion and/or rumour of foul play, the second post mortem can reassure the family that there has been no third party involvement in the death.

3.2.4 a Notification of post mortem examinations

Rule 7 of the Coroners Rules 1984 (coroner to notify persons of post mortem to be made) sets out who the coroner will notify of the time and date of the examination. However it states that the coroner will give that information to "any relative of the deceased who has notified the coroner of his desire to attend, or be represented at, the post mortem examination."[16] The problem is that in the aftermath of a sudden death families are often unaware of this right until the post mortem is over. It should be explained to the family as early as possible that the post mortem examination is mandatory and also what it will entail.

In the short term coroners should be advised that it is good practice to inform the family of the time and date of the examination. Consideration needs to be given to an agreed period of time that should elapse before the post mortem examination goes ahead so that the family can be contacted and have time to consider and act on their options.

In the long term rule 7 should be amended to require the coroner service to inform families of the time and place of the post mortem examination, about their right to have their own representative present and that it can be delayed until they have instructed their own representative if they wish. That would allow them to instruct their own expert to attend and conduct a joint post mortem examination. Ideally, an independent pathologist would work with the coroner's pathologist, thereby ensuring the best possible examination of the forensic evidence and limiting the degree of interference with the body. Pathologists who conduct second post mortems prefer to be present at the first examination arguing that it is a more effective procedure.

As it stands, rule 7 is a very good example of what is wrong with so many of the current coroner's rules. It does not set out rights and entitlements and leaves open the possibility of inconsistent and equivocal practice.

3.2.4 b Providing information to families about post mortem examinations

The fact that consent is not required for a post mortem means that little attention has been paid to the need to provide families with

16. Coroners Rules 1984 7 (2)(a).

information about what it entails. There is as much confusion and variable practice in relation to informing families about post mortems as there is about notification of the death. INQUEST's caseworkers frequently have to explain what a post mortem is and what options the family have. They describe helping "to fill in the gaps created by an information deficit which arises out of the state's inability to provide families with information."

> 'Communication to the bereaved [about the post mortem] did not seem to be a priority with prison/coroner/police, and I was in a state of shock and grief, and therefore unable to assert myself.' [Family of a woman who died in prison]

Caseworkers at INQUEST have also had to explain to families that resuscitation techniques may cause marks on the body that look like injuries; they have to describe what exactly happens to the body during a post mortem.

Families frequently assume the words post mortem and inquest have the same meaning. They are rarely offered the opportunity to learn what happens at a post mortem examination, or that they can delay the funeral until all tissue samples, including organs, have been returned when medical tests are complete. It often takes place before the family has had a chance to view and touch the body and say goodbye. Such interference with the body is contrary to many religious and cultural beliefs; it subjects the body to invasive procedures, often perceived as further violation of the deceased's person.

> '[The] post mortem was already done before I knew he died. I wasn't given any information about a second post mortem.' [Family of a man who died following contact with police]

> 'I felt that the post mortem should NOT have been carried out BEFORE we were informed. I also feel that our permission to carry it out should have been sought.' [Family of a man who died in prison]

In addition to coroners' legal powers and duties in relation to the post mortem,[17] a number of good practice standards are intended to regulate coroners' and pathologists' practice in this area.[18] The Human Tissue Act 2004, implemented in September 2006, requires coroners to obtain consent from bereaved families about what will happen to any tissue samples obtained during the coroner's post mortem once the coroner's purpose is completed. Staff in the coroner service will have to ensure bereaved people have completed consent forms in relation to these samples.

Some coroners now provide information and obtain consent for tissue samples in a sensitive and proactive way. Others do not; many

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17. Coroners Act 1988; Coroners Rules 1984; and Human Tissue Act 2004.
18. Home Office *Model Coroners' Charter* pt 13; Coroners' Society *Practice Notes for Coroners* Appendix A; Home Office leaflet *When Sudden Death Occurs*; Home Office Circular 30/99: *Post mortem examinations and the early release of bodies;* Department of Health *Families and post mortems: A code of practice*, 2003.

bereaved people still receive poor and inadequate information about what is going to happen. The absence of a supportive and informative approach from staff within the coroner service can contribute to making the post mortem examination a source of additional distress.

Families should be given clear and accessible information about the post mortem examination and their options regarding retained tissue both orally and in writing before it takes place. Families should be approached before the post mortem in the same way as if consent were required so that an opportunity is created to inform them of the nature of the process and their status and rights within it.

3.2.4 c Second post mortem examinations

It is important that the information given to bereaved families is comprehensive and an explanation is provided about how to instruct a pathologist to conduct a second post mortem and what it will cost.

> 'Thought should be given about the way in which information is given to bereaved people in shock. Death stops you thinking and taking in details. For example, regarding the second post mortem, information regarding the right should be reiterated a couple of days after the death.' [Family of a woman who died in prison]

> 'I think the shock of the death stops you thinking or taking all the details in. If I had been told about the right to a second post mortem again after a few days, I would probably have liked one done.' [Family of a woman who died in prison]

> 'I was asked if I wanted my own post mortem but they said that I would have to pay for it myself. I said that I could not afford one as I was on income support.' [Family of a man shot dead by police]

Lawyers also report that there is wide variation in practice in relation to care of the body, which has important implications for the conduct of a second post mortem examination. Frequently they are engaged in lengthy and complex written and telephone communication to ensure that the body is properly preserved. Urgent steps should be taken to agree a uniform protocol that ensures the body is preserved and the family and/or their legal representative receive written confirmation of this as a matter of course.

Casework example

A man died following restraint by police officers. There were numerous post mortem examinations carried out. The first, by the coroner's pathologist, did not identify the deep bruising to the deceased's back which was significant as the man was restrained by police officers and these injuries indicated significant pressure to the back. The result of the second post mortem contributed to the outcome of the inquest which concluded that the police had used unlawful, excessive restraint.

In many cases it has been pathologists instructed by families who have ensured that the subsequent inquest has addressed complex, controversial and difficult questions of forensic science, sometimes raised for the first time. Systemic problems and dangerous practices that have

contributed to a number of controversial deaths in custody, for example restraint techniques leading to positional asphyxia, have been identified in this way.

As Thomas *et al* point out, "in the case of death by hanging it is not unusual for families to suspect foul play even though it is actually very difficult to take the life of another person by this means … it is best … to have a second pathologist inspect the body for signs of third party involvement, such as bruising or lacerations. It should not be forgotten that what appears to be a simple suicide can be preceded by other events such as a beating or a fight, and this evidence may be important in investigating what happened."[19]

3.2.4 d Delay

The range of medical procedures carried out to ascertain the cause of death can be complex. Given the ongoing shortage of forensic experts, this frequently leads to delays of months or in some circumstances years before tests are complete. The period before the deceased's body is released to relatives can be prolonged and burial or other religious rites are often delayed. This impacts particularly on those of religious traditions (for instance Islamic or Hindu) whose customs require expeditious burial or cremation.

> '[You] should be able to have a funeral sooner than three weeks.' [Family of a woman who died in prison]

As we said in our earlier report[20] "we have dealt with a significant number of cases where major organs (hearts and brains) have been retained without families' knowledge. This had been a concern of INQUEST's for some time before the Alder Hey scandal drew national attention to the practice – in a number of high profile custody deaths it was subsequently discovered that the heart and/or brain had been retained. It has always been that lack of knowledge about the procedure that has caused the anger and distress. We endorse the sentiments expressed in a report by the Retained Organs Commission:[21]

Casework example

The family of a man who died in police custody waited for over two years to hold the funeral only to discover subsequently that he had been buried without his heart.

'…procedures happened that resulted in short term retention of organs that they (families) did not know about. It is this "not knowing" that has … caused much of the harm. Families said that they were given no information at the time about what would happen at a post mortem… that no explanation or information had been given to them about what would happen. This is not even about the debate on informed consent but merely a question of knowledge. At coroner's post mortems consent (or more properly speaking 'lack of objection') is not required but the

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19. *Inquests: a practitioner's guide*, 2002, para 10.10, p113.
20. *How the inquest system fails bereaved people,* p7.
21. *Report of an Independent Investigation into Organ Retention at Central Manchester and Manchester Children's University Hospitals Trust,* 2002, para 10, p35.

distress caused by "not knowing" is exactly the same. For many …the lack of feedback about the outcome of the post mortem on their child or children rendered the process one which was perceived to be in the interests of practitioners not the patient or their family.'"

> 'Sixteen months after he died I was informed that my son's organs (his brain, heart, lung etc) were sitting on a shelf somewhere. We were absolutely devastated, I kept my son's ashes at home so he was with us always but now I could no longer keep him at home because he wouldn't be complete. No ashes would come from his organs. So I had to arrange for him to be in a cemetery for his organs to be buried with his ashes. So all you go through with the first funeral, you have to go through it all with the second.' [Family of a man who died in police custody]

There is also variable practice about disclosure of the draft report of the first post mortem to pathologists instructed by families which contributes to delay. In some cases families have delayed funerals so that their own pathologist can consider the first report and decide whether a second post mortem examination is necessary. The initial draft post mortem report, setting out what examinations have taken place and early findings (excluding toxicology or other reports that may take some time to complete) should be released to the family as a matter of urgency.

3.2.4 e The post mortem report

Once the medical procedures are complete the family is entitled to a copy of the post mortem report. The Coroners Rules 1984 r57 (1) require the coroner to supply a copy of the post mortem report to "any person who in the opinion of the coroner is a properly interested person" on payment of the prescribed fee. Families are often given no guidance about the meaning of the contents of the report or offered advice about who to contact to discuss the report. In any new system bereaved families should be automatically made aware that they are entitled to a copy of the post mortem report. The fee for the post mortem report should be abolished. Families should be able to choose to receive the report in a manner that facilitates their understanding of its findings. For example, they might wish to be advised by their GP, by the pathologist involved, or by a specialist family advisor in the Coroners Court, or by their lawyer.

3.3 Provision of Information and Support

We have shown there is inadequate provision of information and support at all stages in the immediate aftermath of a death in custody. In this section, we note the impact of this lack of information and support on the capacity of families to effectively participate in the investigation and inquest process. We consider what can be done immediately to make information and support available and what should be done in future.

The absence of an independent source of support is an obstacle to families as they try to negotiate the inquest and investigation system. Inquests into deaths in detention are particularly complex; without access to specialist legal advice meaningful participation in the inquest process is hindered.

> 'When I asked the coroner's officer, should I get legal advice, he said "well it's up to you" but he felt he was pretty sure my son had died from a cocaine overdose and the inquest would last half a day to a day. No I wasn't told about inquests.' [Family of a man who died following contact with police]

'Coroner's officers tend to tell families what the verdict is going to be, and usually quite wrongly, they'll say "this is going to be natural causes and no, you don't need a solicitor"' [Solicitor, Leeds]

It is important that bereaved families are able to access independent legal advice immediately. In all deaths in detention the institution or state agents involved will be legally represented from the outset. Recently some coroners have been concerned to ensure families are also represented as they recognise that this can improve the conduct and outcome of the inquest. Legal practitioners are now more aware of the issues raised by deaths in detention but it remains a highly specialised area of law and families must be able to access lawyers with relevant experience and expertise.

> '[It is] important that very specialised solicitors are used to tackle the Coroners Courts, who are economical with the truth, or they will do as they please.' [Family of a young man who died in prison]

> 'I dread to think how things would be if I had not got a proper solicitor who knew what he was doing.' [Family of a man who died in prison]

In chapter 5 we discuss in more detail the problems of legal preparation and representation. However, those who have immediate contact with the family after the death can have a crucial role in ensuring families seek advice from lawyers with adequate qualifications and experience.

> '[I would have liked to have been given] more reading. To know of any help available and be given the details of solicitors.' [Family of a man who died in prison]

A number of agencies (the coroner service, the voluntary sector, the institutions of detention and the investigation bodies) could be expected to provide information and support to bereaved families, but at present the process is disjointed and confusing.

> 'Families should be advised of their rights and where to go for help.' [Family of a man who died following contact with police]

> 'Information should be disseminated rather than the family having to search for it. Put families in touch with lobbying groups as it is a great help.' [Family of a man who died in prison]

In the absence of a comprehensive statutory service, INQUEST continues to provide a generic information service to any family bereaved in circumstances requiring an inquest, and a unique casework service to families bereaved by deaths in custody. It publishes *Inquests – An Information Pack for Families, Friends and Advisors*[22] – which explains the whole process and where to find emotional and practical support. It includes eight sections covering the whole process, specialist information about particular circumstances of death, contact details of relevant statutory and voluntary organisations, a glossary, etc. Within the pack and also available separately are two dedicated leaflets *What to do when someone you know dies in prison/police custody*. The pack was launched in August 2003 and 1000 printed copies have been distributed. Since it was made available on INQUEST's website in August 2004 it has been downloaded over 6000 times.[23] INQUEST's pack is the only comprehensive information available and everyone who needs it should have access to it. However, it is not satisfactory for the voluntary sector to have to seek charitable funds to produce an information pack that should be provided by the coroner service.

> '[We need] an information pack with telephone numbers and specialists listed, explaining the procedures.' [Family of a man who died in police custody]

In the long term, the service provided by INQUEST should be complementary to a properly resourced and comprehensive support service provided by the coroner service that should ensure families receive all the basic support and information they require. In the next sections we look at what is available at present.

3.3.1 The role of the coroner service

Considering practice across the whole coroner service, the provision of basic information about what will happen following a death in detention is poor; for families this failure has damaging further significance as it hinders effective participation in the investigation processes.

Families require clear information from the coroner service about inquest procedures. A short leaflet, *When Sudden Death Occurs*, is produced by the Department for Constitutional Affairs (DCA) but it is not routinely distributed to families by coroners: our casework and monitoring shows that only a third of families received a copy.

It is available on the DCA website but this presupposes that the families have access to technological resources and the skills to use them; families should not have to seek out this information – it should be disseminated to them. Even if the DCA leaflet were widely available, on its own it still falls short of providing enough information and does not signpost people to other sources of information and

22. INQUEST 2003, free for bereaved families and also available from www.inquest.org.uk
23. INQUEST monitoring August 2004 – December 2005.

support. For instance, it has no information about how to obtain legal representation or about the kind of investigation that will take place into the death.

Officials in the DCA and some coroners have recognised that more comprehensive material is needed. Some coroners now give families copies of INQUEST's information pack and others have bought copies to distribute. Some have their own leaflets, and some have information on local authority websites; but there is little co-ordination and quality control.

In the short term, all coroners should follow the example of the minority of their colleagues and ensure that they make this pack available. The coroner service should ensure families have access to one named person who can answer their questions whenever they arise.

In the longer term, the DCA should provide a new national coroner service with an equivalent publication to be distributed to families. The independent publications of the voluntary sector should also be made available alongside this. The aim should be to ensure families understand what their rights are, reflect on their choices and decide what to do next.

> 'We were given leaflets from the coroner's office but given no advice on support. INQUEST was found by myself whilst searching on the internet.' [Family of a man who died in prison]

> 'Families should be supported in the immediate aftermath rather than given [phone] numbers and left to find everything out for themselves.' [Family of a woman who died in prison]

To better facilitate the provision of information and support in a reformed system, a new post of Family Support Worker (FSW) should be established. The FSW would be qualified in social work and also have experience in working with bereavement. They would not be a coroner's officer but provide a specific support and advice service to bereaved people. The FSW could answer families' queries as and when they arise, take them through the process at a pace appropriate for their psychological state and refer them to specialist advice and support if necessary. Consideration should be given to ensuring that those informing families of a death are accompanied by the FSW from the nearest Coroners Court.

The FSW should send a letter to the family setting out the service available from the Coroners Court, including an information pack and any relevant information from the voluntary sector. Such a letter should be sent to all families by the coroner's current staff prior to the reform of the system. In cases of deaths in custody either INQUEST's information pack or specialist leaflets should be enclosed.

A better standard of treatment from the coroner service could be expected to have an important effect on how bereaved people cope with the combination of a sudden death in custody and subsequent inquest. Although knowledge cannot prepare people for every aspect

of the investigation and inquest process, we know from experience that clear and accessible information can ensure that the inquest does not cause additional distress.

We believe in the long term that if the coroner service is improved; if the legal profession ensures that legal practice surrounding inquests is of a higher standard and better regulated (see chapter 5); if bereavement and counselling agencies have a better understanding of the support needs of families bereaved by deaths in detention (see chapter 6); then the basic needs of these families will be met. They could then choose whether they felt it relevant or necessary to access the services of the voluntary sector. The voluntary sector in turn would be freed up to provide its specialist service. Currently the voluntary sector is providing too much basic support and advice that should be properly provided by the statutory system.

3.3.2 The role of the voluntary sector

Alongside official organisations there are bereavement and advice organisations families may turn to for support and advice. Different organisations play different roles to deliver the services bereaved people want and need. Needs are complex and change over time and it may be that a family bereaved by a death in custody is in contact with a number of different organisations.

In the main, those who contact generic advice agencies, for instance local CABx and Law Centres, receive a variable service in the quality of knowledge about the inquest system offered and the extent of appropriate referral to specialist advice.

We surveyed both generic advice agencies and specialist organisations to find out what is available to bereaved families. The following organisations participated in the survey:

- Action Against Medical Accidents
- The Carbon Monoxide and Gas Safety Society
- Centre for Corporate Accountability
- The Child Bereavement Trust
- The Compassionate Friends
- CRUSE Bereavement Care
- Epilepsy Bereaved
- Liberty
- MIND
- National Association of Citizens Advice Bureaux
- National Bereavement Partnership
- National Civil Rights Movement
- Rethink
- RoadPeace
- Support after Murder or Manslaughter
- Survivors of Bereavement by Suicide
- Victim Support

The results of the survey point to a voluntary sector that has developed because of the poor service provided by the state. It is

under-resourced and plugging gaps that should be part of the basic statutory service. The survey also highlights a need for the voluntary sector itself to improve its understanding of the needs of families bereaved by deaths in custody and of the services available to them.

There is a small and specialised group of voluntary sector organisations that work with bereaved families, fewer working with families bereaved by a contentious death and only one, INQUEST, that specialises in giving advice and assistance to families bereaved by a death in custody. Because of the small number of organisations involved in this area of work we anticipated that each would be acquainted with the work of the others and refer families appropriately, depending on the particular context in which the death occurred.

Instead we found that the voluntary sector, including INQUEST, is not working as effectively as it could to share information and provide the most appropriate support for families. For example, a recent Victim Support[24] report identifies a gap in information about the inquest system provided to families of murder victims. The authors of the report appear to be unaware that INQUEST has a generic information pack freely available to bereaved families and downloadable from its website.

> 'A family member had seen a small piece in a newspaper with a quote from somebody at INQUEST. We then went in search of your telephone number and made contact. No information, advice or support came from any other body. Victim Support did not know what to say or do when they heard it was [the] police who were the killers.' [Family of a man shot dead by police]

The survey was conducted by telephone as a simple test to examine how easy it is to speak directly to an advisor. 75% of organisations answered the call immediately. Of those who did not only one had an answering machine advertising the availability of telephone advice.

Each phone call asking for help requires a family member to relate their case details, which will inevitably be a difficult experience. Many families have told us how much courage it takes to pick up the phone and be ready to discuss the death of a relative in custody with a stranger. They have explained how painful it is to have to tell the story again and again and how anxious it can make them worrying about what the advisor might think about them because their relative died in custody. They have also complained about INQUEST's use of an answering machine at busy times or out of office hours as similarly very off-putting.

'It is sometimes a thankless task referring on a bereaved family to another organisation when the referrer does not know for sure if the

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24. *In the Aftermath: the support needs of people bereaved by homicide,* 2006.

family will be able to access the sort of help they need. It feels like passing the buck whereas it would be nice to be confident when making a referral that it is appropriate and the organisation signposted will be able to provide the kind of help required.' [Voluntary advice worker]

> 'After contacting so many different groups it is great to finally find someone who can help.' [Family member]

Most organisations said they did provide advice on the inquest system, mainly by phone. Only one third provided written information. 56% would refer an individual to INQUEST if the query was about a death in custody. The alternatives were predominantly referral to a solicitor but included the CABx, the NHS Ombudsman, coroners and the coroners' unit at the Home Office.

'Talking to you makes me realise that we should maybe be providing more information. Where demand grows for information of a certain type, we try to provide it, but the range of subjects we cover is very wide and the advice service is very generalist.' [Generic advice worker]

There are specialist sources of support available and it is important that the voluntary sector and the coroner service signpost people appropriately.

> 'I was given no information about INQUEST. I was only offered contact details of suicide bereavement support which I already had access to through my job.' [Family of a man who died in prison]

> 'The contact with INQUEST was invaluable. Families feel they have nowhere to turn. We can't go to the police. Also a lot of the usual agencies do not seem to want to help e.g. Victim Support. We felt we could finally get the information we needed from somebody we trusted.' [Family of a man shot dead by police]

The burden of providing basic information about the inquest system is currently placed on the voluntary sector which is working on an unpopular and hard to fund issue. The sector is effectively subsidising the current coroner service, rather than providing a complementary and value added service to bereaved families. As argued above, basic information and support should be delivered by the coroner service. Voluntary sector organisations have an important contribution to make both in providing specialist support and advice to bereaved families and in raising the policy issues emerging from the investigation of deaths in particular circumstances. Charities and community groups should meet regularly to ensure that each organisation has a better idea of each other's work and fields of expertise. But to do this the sector needs better resources. Consideration should be given by the DCA to funding such an initiative.

3.3.3 The role of institutions of detention and investigation bodies

In the immediate aftermath of a death, the Prison Service, police, Independent Police Complaints Commission and the Prisons and Probation Ombudsman can play an additional important role in providing information to bereaved families about a range of matters including where to obtain legal advice and practical support. There is no statutory duty on the investigation bodies to advise bereaved people on the availability of specialist advice but they are well placed and resourced to do so.

If the coroner has not already provided the information necessary for participation, investigation bodies can ensure families do not fall through the net; if they have already received the information it can be helpful for them to be reminded of their options. In particular, this is significant if consideration needs to be given to a second post mortem, for help with funeral expenses, for access to personal property and to initial advice about what is going to happen regarding the investigation and inquest.

There are a number of opportunities for signposting families when the death occurs in prison or police custody:

1. Police officers who may inform the family of a death in prison or police custody.
2. The IPCC who investigate a death in police custody;
3. Prison staff who may inform the family of a death in prison;
4. The police officers who may be investigating a suspicious death in prison;
5. The Prisons and Probation Ombudsman who will investigate a death in prison.

Casework example

Following the death of a 17 year old boy found hanging in a cell in a young offender institution, a Detective Sergeant from the family's local police force rang INQUEST and passed on the family's details so that we were able to contact them directly. Early support meant that they could get on with arranging the funeral and the grieving process safe in the knowledge that we were in contact, had a solicitor arranged to meet them when they were ready and another bereaved family available to talk to them for more immediate emotional support.

> 'Families who have lost loved ones in any institution due to suspicious circumstances should be informed/ notified by the authorities of all available pressure groups, e.g. INQUEST.' [Family of a man who died in police custody]

'I did think the prison service should have told us about INQUEST but they did not, they were very cold towards us and showed us no sympathy at all.' [Family of a man who died in prison]

'No help or information was given to us through the Prison Service, Home Office, [or] Board of Visitors. I had to find and

Casework example

Following the death of a woman in prison in 2006 her sister was visited by the governor and assistant governor within days of the death and given a personal letter from INQUEST and its information pack. She was then in a position to contact INQUEST at an early point. She was also given a named contact at the prison and has had regular and positive contact thereafter.

search for help and information on the internet where I found INQUEST, which led me to a professional solicitor who dealt with deaths in custody.' [Family of a man who died in prison]

Some families have had positive experiences but currently this is dependent on individual approaches and not on required standards of service delivery.

Families rarely receive INQUEST's specialist leaflets *What to do when someone you know dies in prison/police custody* from the Independent Police Complaints Commission/Prisons and Probation Ombudsman or are advised to contact INQUEST. There is still a reluctance to inform families about INQUEST. Information about the organisation is either not given to families at all, or the service is just mentioned in a letter written by the investigation bodies without supporting materials, or details are included alongside a range of other advice and support groups none of whom deliver the kind of legal and practical support and specialist service provided by INQUEST.

Casework example

The family of a man who died in police custody in November 2005 were not given INQUEST's details by the IPCC's Family Liaison Manager (FLM) who they had met on a number of occasions. They found information about INQUEST whilst searching for help on the internet. The FLM confirmed that the information pack provided by the IPCC should contain leaflets about INQUEST and their services. The family stated that they did not receive this leaflet for which the IPCC apologised. When the family asked the FLM whether they should seek legal advice she stated, "it's up to you" and gave no further advice.

'Information packs should be on hand in police stations/prisons etc, telling them all about your work.' [Family of man shot dead by police]

'We were left to ourselves at the beginning. I feel that when someone dies in a prison, police station etc. it should be compulsory for them to give families names and numbers of organisations like yourselves to support these families.' [Family of a man who died in prison]

The new investigation bodies need to be alert to the possibility that they may be prone to repeating the same poor practice of their predecessors, with potentially damaging consequences for the families involved.

'I was led to believe that the Prison Service would be supportive, open and give me all the information I would need. Instead they did not stick to their agreement on regular contact and I became aware they would have legal representation which did not support my husband's interests. INQUEST found a solicitor and attended the first interview.' [Family of a man who died in prison]

Casework example

The father of a man who died in police custody in December 2005 had not met anyone from the IPCC following the death of his son. He did not get any information about INQUEST from the police. INQUEST arranged a solicitor and following a meeting the family are considering whether they will continue participating in the process without a solicitor. The family want to make this decision now that they are aware of what all their options are.

> I was given no information about support. I found INQUEST myself via a sympathetic pathologist who I phoned myself. I phoned the Law Society for help finding a solicitor, they could not recommend anybody and said I should go to the library! A member of the PCA told me that he knew of a very good support group but he told me at the inquest, two and a half years after (my son) had died. [Family of a man who died in police custody]

These practices do not give the family a sense of what INQUEST does and what kind of organisation it is and are in stark contrast to the situation for victims of crime where a letter is sent by the police to every crime victim, unless they specifically say they want no contact, highlighting the service provided by Victim Support and enclosing a booklet produced by them which explains who they are and the service they provide. In the short term, before any substantial reform of the inquest system, this discrepancy needs to be addressed.

Casework example

Following a death in prison, a caseworker involved in an unrelated case expressed concern about the lack of contact with the family, which led to a proactive response from the PPO Family Liaison Officer. The FLO agreed to call the family and remind them of the service INQUEST offers. As a result the next day the family were in touch. They had been having problems finding a solicitor. As a result of this contact a solicitor was found and the family have stated that they wish they had been made more aware of the service that we can provide. This example underlines the need for there to be regular contact with families so that they can be reminded about available sources of advice and support.

3.4 Concluding remarks

The experience of many families is poor, and compounded by the politics[26] surrounding deaths in custody. The circumstances and location of many of the deaths inherently attract prejudice, strong negative feelings or little sympathy. Families do not experience the post death investigation and inquest system as compassionate and have to overcome substantial obstacles to find out the truth. Families need to receive accessible and accurate information about the circumstances of the death of their relative and where they can seek advice and support. They need accurate and timely notification of the death and accessible information about what will then occur – post mortem, investigation and inquest – and who to contact to ask for advice about any aspect of post death procedures.

In the short term the coroner service and those informing families of a death should make information available so that families can choose whether or not to access independent support. All deaths in custody involve an inquest, so the potential role of the coroner service in guaranteeing informed and effective access to appropriate advice and support options for bereaved families must be a central concern in developing a new system. Mandatory provision of this information would at least give families *the informed choice* to contact INQUEST or not.

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26. See discussion in Chapter 2.

The needs of families bereaved by deaths in custody are complex and each organisation must have a clear remit and understand the roles that other organisations play in order to facilitate better joint working.

The Department for Constitutional Affairs should ensure immediately that all Coroners Courts have copies of INQUEST's information pack and leaflets.

In the long term the reformed coroner service should include a Family Support Worker (FSW) in every region to provide basic information and advice about post death investigations and inquests. The FSW would also provide some support and referral to specialist advice where necessary. All coroners, coroner's officers, relevant Prison Service staff, and staff of the Prisons and Probation Ombudsman and Independent Police Complaints Commission should be aware of the availability of INQUEST's information pack and leaflets.

Recommendations

Notification of the Death

1. There should be agreed protocols and standards about notification of death across the police and prison service to ensure:
a. it is a priority for all institutions to notify the family as soon as possible after a death;
b. those delivering the news should be accompanied by a Family Support Worker from the coroner service;
c. no information is released to the media until the family has been notified;
d. that there is a transparent process for the release of information;
e. there is mandatory basic training for anyone who may be involved so they can notify with accuracy, clarity and sensitivity;
f. staff receive proper and professional support;
g. training is updated at regular intervals.

2. Families should be:
a. told face to face about a death where possible by someone who can give information about the death and about what will happen next and who else will be involved;
b. offered the opportunity to meet the relevant senior official and to visit the scene of the death if they wish.

3. Staff should ensure:
a. that the relative has appropriate support mechanisms available;
b. that all information about the death and subsequent procedures given orally is duplicated in writing;
c. that a direct phone number and contact name that can be reached out of hours is left for the family;
d. that they give only accurate information about the circumstances of the death so that families are told the truth, however painful.

In the short term co-ordinating a unified approach to notification

and provision of information involving multi-disciplinary groups could be addressed in the recently established Forum for Preventing Deaths in Custody .

Access to the body and the post mortem examination

4. The coroner service needs to ensure that bereaved families:

a. are told as soon as possible that the post mortem examination is mandatory;
b. are given clear and accessible oral and written information about the post mortem examination and their options regarding retained tissue before it takes place;
c. receive written confirmation that the body is preserved according to an agreed protocol, either directly or through their legal representative;
d. are able to view the body as soon as they wish and particularly before the post mortem examination;
e. are informed of the time and location of the examination and have time to consider and act on their options within an agreed period of time before the examination goes ahead;
f. have the initial draft post mortem report released to them, setting out what examinations have taken place and early findings (excluding toxicology or other reports that may take some time to complete) as a matter of urgency;
g. are informed if organs are removed and not replaced before the time of the funeral;
h. are automatically made aware that they are entitled to a copy of the post mortem report and the fee for provision of the report is abolished.

5. Those working with bereaved families must:

a. be aware that some faiths have post death rituals that will be interrupted if physical access to the body is prevented and understand that it can cause additional distress;
b. understand the impact of the issue of ownership of the body.

In the longer term coroners rule 7 should be amended to require the coroner service to inform families of the time and location of the post mortem examination and their right to have their own representative present; and to allow the examination to be delayed until the family has instructed their own representative if that is their wish.

Provision of Information

6. The coroner service should ensure that bereaved families:

a. receive a copy of the leaflet *When Sudden Death Occurs*;
b. receive a copy of INQUEST's information pack;
c. have access to one named person in the Coroners Court who can answer their questions throughout the duration of their contact with the service.

7. In the long term:

a. the service provided by INQUEST should be complementary to a properly resourced and comprehensive support service provided by the coroner service ensuring that families receive all the basic support they require;
b. the DCA should provide a new national coroner service with a comprehensive information pack for families;
c. the independent publications of the voluntary sector should be made available alongside this pack;
d. a new post of Family Support Worker (FSW) should be established which is distinct from the coroner's officer;
e. the FSW in each jurisdiction could assist with notification of local families irrespective of location of death, provide support and advice and be available on an ongoing basis to answer queries about any aspect of the procedures that follow a sudden death;
f. the FSW would be trained and knowledgeable about the needs of bereaved families and about specialist, complementary services available;
g. the FSW would have a social work qualification and experience in working with bereaved people.

The Voluntary Sector

8. The sector needs more resources to co-ordinate and ensure seamless delivery of its services. Voluntary sector groups should meet regularly to ensure good communication, appropriate referral and understanding of each group's remit and expertise. Consideration should be given by the DCA to funding such an initiative.

Chapter 4: The Investigation

"The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others." (Amin judgment)[1]

"Where deaths in custody take place the question of 'how' a person died cannot be meaningfully explained by a mechanical and isolated inquiry into the means by which he or she died. This is because the death takes place within a system of dependency and control. For people confined to or dependent upon such systems their existence literally cannot be understood in isolation from their circumstances. In seeking to extend the ambit of the inquiry into an exploration of the system, the families have been, primarily, attempting to explore the full meaning of the death." (Thomas *et al*)[2]

"The opportunities for family participation are not only impeded by the pain of bereavement, they are effectively undermined by an insensitive and intrinsically unjust 'investigatory' process that is itself protected by self-interest and institutional defensiveness." (Goldson and Coles)[3]

"In future, the family of the deceased must play a full part in the processes of investigation and certification." (Shipman Inquiry Third Report)[4]

> 'I wanted ALL investigations concerning my daughter's death to be conducted with the utmost vigour (i.e. police, prisons and probation ombudsman) but this did NOT happen. I wanted to be kept fully informed and to know that was happening at all stages, but this also did not happen.' [Family of a woman who died in prison]

4.0 Introduction

In this chapter, we consider what bereaved families expect from the investigation following a death in custody and what the investigation bodies are obliged to provide. We underline the importance of legal representation for families. We outline the stages of investigations following deaths in prison and police custody and consider the provision of information to families about the process. Continuing the timeline of families' experiences of interaction with the system, we discuss problems arising from the role of family liaison officers and

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1. *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51 para 31.
2. *Inquests: a practitioner's guide,* 2002, p27.
3. *In the care of the state?,* 2005, p83.
4. *Death Certification and the Investigation of Deaths by Coroners,* 2003, p487.

the conduct of investigators' interviews with families. We then examine problems with families' access to information about the ongoing investigation, the release of documentary information during the investigation, the lack of explanation for delays, and difficulties in obtaining investigation reports. As we highlight concerns about the shortcomings of the current system, we present evidence from experienced practitioners together with the families' and our own recommendations for change.

4.1 Family participation and human rights

Notwithstanding human rights obligations that have rested with the detaining authorities (the police, prisons, immigration service), custodial deaths have continued in remorseless and unacceptable numbers for many years (see chapter 2). The state has responded to public and parliamentary disquiet by trying to improve investigation systems and custodial regimes with the assistance of experts and advisors.[5] Through involvement in this process those who work with bereaved families have endeavoured to give voice to their concerns. The contribution of families is acknowledged and enshrined in various written protocols, mission statements and guidance.

4.1.1 Implications of the Human Rights Act 1998 for the investigation process

Establishing new investigation processes for custodial deaths was designed to provide independence as a duty of compliance with the Human Rights Act. Providing insight and explanation to bereaved families and the learning of lessons are key terms of reference for the Independent Police Complaints Commission (IPCC) and the Prisons and Probation Ombudsman (PPO) investigations.

Bereaved families now have a number of legitimate expectations with regard to the conduct of custodial death investigations. Both domestic and European law and legal cases such as *Edwards*[6] and *Amin* have put bereaved families at the centre of the investigative process. Crucially the centrality of families is not recognised in order to ensure fair treatment of the bereaved, but in order to discharge the duty of the state to conduct an effective investigation. The issue is how easily families can participate effectively in the investigation process with the necessary information, support and resources.

The thoroughness, quality and value of investigations can be significantly improved by the effective participation of the family. However many of the current procedures do not enshrine rights and entitlements to assist such participation. Too often they afford to the detaining authority discretions rather than enforcing mandatory

5. Ministerial Group on Prison Suicides (from 1998), Independent Police Complaints Commission Advisory Group (from 2004), Forum for Preventing Deaths in Custody (from November 2005), Department of Constitutional Affairs Stakeholder Group (from June 2004).
6. *Edwards v UK* [2002] 35 EHRR 19.

practice in crucial areas such as pre-inquest disclosure of information, access to legal representation and provision of information about sources of independent advice and support.

As discussed in chapter 2, the *Middleton* judgment established that it is the combination of the investigation process and the inquest that constitute the ability of the family to 'effectively participate'. Failure to enable a family to participate effectively in the investigation, whether through lack of finances or lack of information, would result in the state being in breach of its article 2 obligations.

4.1.2 The investigation and family expectations

"[The Committee] met family and relatives of people who had died in custody, who raised serious concerns about the authorities' response to the death, the information provided to the family, and the extent to which they had been involved in inquiries." (Parliamentary JCHR)[7]

> 'The investigation should be done by a completely independent body with no bias to police or public but just to find out truth and justice and factual knowledge. [Family of a man who died in a police vehicle incident]

Special duties arise where the state has responsibility for the safety of detainees in a closed and controlled environment. An individual in custody, for however short a period, has had their liberty removed. They may be subject to the use of force by state agents. When in custody, the individual is reliant on the state for medical care, including care of their mental health, treatment for drug and/or alcohol problems or withdrawal. The state has control of, and therefore responsibility for, each of these ordinary facets of individual autonomy. Those charged with administrating the environment of a person in custody therefore assume as agents of the state a duty of care. Most importantly, that duty of care involves a protection of the deceased's right to life: "When the state takes away a person's liberty, it assumes full responsibility for protecting their human rights."[8]

The question of law that any family bereaved by a death in custody wants an answer to is 'was that duty of care exercised' and 'were the relevant protocols and guidance followed?' In cases that involve deaths as a result of the use of force – shootings or restraint related deaths – the question is often 'was the use of force unlawful and excessive?'

The family asks 'was everything done that should have been, to care for the deceased while in the custody and care of the state?' Families want to know whether those responsible for the care of their relative did their jobs properly. It is not just a question of whether custodians acted within the existing guidelines but of the effectiveness of such guidelines and their preventative function.

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7. *Deaths in Custody: Third Report of Session 2004-05 Vol I*, 2004, para 286, p81.
8. *Ibid*, p5.

Evidence of the movements of all concerned must be looked at, medical records have to be checked, compliance with state agencies' policies, procedures and practices, and their adequacy in relation to the supervision, management and care of at risk detainees must be explored. Compilation and analysis of the extensive documentation that accompanies any person held in custody must be undertaken.

"In human terms, thoroughly conducted coronial inquiries hold the potential to identify failures in custodial practices and procedures which may, if acted on, prevent future deaths in similar circumstances. In the final analysis adequate post death investigations have the potential to save lives" (Royal Commission into Aboriginal Deaths in Custody)[9]

Answers to the following basic questions about the investigation must be available to families:

- when does it start;
- who carries it out;
- where will it be carried out;
- who is it carried out for;
- what is its remit;
- how long does it take;
- who is the point of contact;
- how to raise concerns;
- how to access documents;
- how to find a lawyer;
- how to obtain financial help.

Families have very clear expectations of what they want from the investigation: an explanation of how and why the deceased died and access to all the relevant facts. Their needs are twofold – to speedily find out as much as possible about how and why their relative died, and for lessons to be learned to prevent other deaths. It is important for them to hear directly from and hold to account those responsible both at an individual and senior management level.

4.1.3 Effective family participation and legal representation

Enabling family participation in what is a lengthy and often alienating process should be a central concern of any investigation. Ultimately, participation can make the experience more bearable for the family by giving some meaning to their loss. Family involvement also humanises the legal process, thereby acting as a reminder that the investigation is into the death of a human being who was someone's partner, parent, child and/or sibling. Without family participation it can become a mechanical and isolated process.

Participation is most effective when the family feels a living part of the investigation, is treated respectfully by the investigation bodies and can keep its boundaries and maintain its dignity. Their involvement may be either direct or through a solicitor who feeds back to the

9. *National Report*, 1991, para 4.7.4.

family throughout the process. Access to sympathetic specialist legal representation from the outset can greatly assist a family. Barriers to legal representation are discussed extensively in chapter 5, however families need representation throughout the investigation not just for the inquest hearing.

Prior to the introduction of voluntary Home Office protocols on disclosure in 1999 and the establishment of the new investigation bodies, families were largely excluded from the investigation process and disclosure of documentary evidence was extremely limited. The broadening of the scope of both the investigation and inquest into a death in custody means there is a real opportunity for families to play a role.

With increased disclosure there is increased need for legal preparation. To fully involve and engage with a family during the course of an investigation, legal representatives require regular communication and meetings with the family, to review disclosed documents and statements and time to work with the family to draft a statement about the deceased and their concerns about the death. A relationship of trust is built up with the solicitor so that the family feels its views and needs are central to the process.

Families can participate in the process if they are guided and encouraged through the maze of agencies and professionals involved. Furthermore, the investigation is more successful if families are properly represented. The specialist knowledge experienced lawyers bring to the process can help shape and influence the official investigation and ensure that the relevant issues are explored fully. The circumstances of death are scrutinised more closely which impacts on the thoroughness of the subsequent inquest and increases the likelihood of a more meaningful outcome at its conclusion (see chapter 5).

4.2 The investigation processes

"The [JCHR] report considers how the state responds following a death in custody…and the report emphasizes the need to ensure that families are informed, supported and involved immediately following a death and at all stages of the investigation."[10]

"I decry those who fail to acknowledge the significant changes for the better that have occurred." (Prisons and Probation Ombudsman for England and Wales)[11]

"The Prison Service Order should be reconsidered to give greater recognition of the place of families in this process; firstly, to take account of the help they could offer and secondly to acknowledge their legitimate interest in the process." (HM Chief Inspector of Prisons)[12]

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10. *Deaths in Custody: Third Report of Session 2004-05 Vol I* , 2004, p6.
11. *Deaths in Custody Interim Report: First Report of Session 2003-04* 2004, Ev 67-68.
12. *Suicide is Everyone's Concern: A Thematic Review,* 1999, p55.

The question of the independence of investigations into deaths in custody has been highly contentious (chapter 2). In April 2004 the systems changed in relation to the investigation of deaths in both prison and police custody. This report covers the period of transition between the old and new investigation systems.

4.2.1 The investigation of deaths in prison

Prior to April 2004 deaths in prison were investigated by internal Prison Service investigators. These investigations were often extremely poor, limited in scope and focused narrowly on claims about individual pathology of the deceased rather than examining the broader context in which the deaths took place. There were no agreed procedures about family involvement and only a voluntary protocol was introduced in 1999 regarding pre-inquest disclosure.

Since April 2004, the Prisons and Probation Ombudsman (PPO) has been responsible for the investigation of all deaths in prisons, deaths of residents in approved premises (probation hostels) and immigration detention accommodation. The Ombudsman is appointed by the Home Office, the government department with responsibility for prisons. The investigatory function of the PPO is exercised on a non-statutory basis, in contrast to the IPPC (see below). The PPO sets the terms of reference for each investigation which will vary according to the circumstances of the death. One of its key aims is to provide insight and explanation to bereaved relatives but that is not its sole function. The investigation serves a different purpose for each stakeholder and tensions may arise between the different functions.

The Ombudsman will be informed of a death by the Prison Service/Probation Service/immigration service.[13] One of the Ombudsman's team of investigators will be appointed to conduct the investigation. The investigation usually commences within 72 hours of the death being reported; it involves a visit to the establishment where the death took place. The Ombudsman has Family Liaison Officers (FLOs) who make contact with the family within 20 working days by telephone or letter. The appointed FLO will be the family's link to the investigation throughout the process. They offer to visit the family and follow up with a letter outlining the issues discussed. Unless the family requests another meeting, the next contact is usually made when the draft investigation report is available.

The draft report is circulated to the family and Prison Service. Depending on feedback received there can be considerable delay between the receipt of the draft report and the final report being completed to take into account comments from different stakeholders. The final report may also differ substantially from the draft having

13. We are aware of a number of cases where there has been a delay in the prison service informing the PPO about a death in prison. This undermines their ability to begin their investigation and identify and interview key witnesses, particularly other prisoners who may have completed their sentence or transferred to a different prison by the time the investigation gets underway.

been rewritten after lengthy consultation with the Prison Service and any criticisms made in earlier drafts may be dampened down or removed. It can be difficult for the family to accept changes, particularly where an earlier draft was more critical.

There may be more than one investigation into a death in prison. The police may conduct a parallel criminal investigation which has primacy over investigations by the PPO. In such cases, there may well be no PPO investigation and by default no communication with the family. Instead, a police FLO will be appointed who should be the point of contact with the family during the course of their investigation.

To date there is no clear policy on the minimum standards of investigation. However in our experience PPO investigations have been broader in scope than previous Prison Service investigations.

4.2.2 Investigations into deaths in police custody

Prior to April 2004 the Police Complaints Authority was responsible for the supervision of investigations into deaths in police custody. The investigations were always conducted by police officers who reported to a member of the Authority. In some cases the force investigating was different from the force involved in the death. In other cases it was the same force.

Since 1 April 2004 responsibility for the investigation of deaths while in the care or custody of the police rests with the Independent Police Complaints Commission (IPCC), which oversees the police complaints system in England and Wales. It was set up by the Police Reform Act 2002. Therefore, unlike the PPO, it is on a statutory footing and has significantly more resources.

All deaths in custody must be reported to the IPCC: "Forces should refer complaints or incidents as soon as practicable and no later than the end of the working day following the day when it becomes clear to the force that it should be referred. The IPCC provides a 24-hour on-call facility to the police service."[14]

Although the investigation body is called the Independent Police Complaints Commission, not every death in custody is investigated independently. There could be one of three types of investigation:15 supervised, managed and IPCC conducted investigations.

1. Supervised investigation – undertaken by the police under the supervision of an IPCC Commissioner; it is led by an investigating officer from the police.
2. Managed investigation – carried out by the police but the IPCC has control and is in charge of the investigation; the choice of police investigating officer must be approved by the IPCC Commissioner.
3. IPCC investigations – carried out by the IPCC's independent investigators; an IPCC Commissioner supervises the investigation.

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14. *Making the new police complaints system work better,* 2005, para 5.6.6, p34.
15. How this is determined by the IPCC is set out in the document *Investigations Criteria* published in June 2004 and available on the IPCC website.

The commissioner appoints an IPCC senior investigator who takes charge of the investigation on behalf of the Commission, assisted by a deputy senior investigator to deal with day to day enquiries.

The IPPC published its statutory guidance in October 2005.[16] The guidance came into effect on 1 December 2005. It is primarily a document aimed at the police and although publicly available it is not a lay person's guide to what will happen during an investigation. It does stress the importance of openness and transparency about the terms of reference of the investigation and the need for regular updates on its progress and expected timescale.

There is a huge gap between the detailed legalistic statutory guidance and the very limited information contained in the leaflet for bereaved families, *Step by step,* provided by the IPCC.

A dedicated Family Liaison Manager (FLM)[17] will be part of the investigation team. The FLM's role is to ensure that the family are provided with appropriate support and communication about the progress of the investigation. However FLMs are also employed as junior investigators and there exists the potential for families to be confused about their role. It is unclear whether FLMs are there to support the family or to investigate them (see 4.3.1 below). Another source of confusion arises where the police force in whose custody the death occurred appoints its own Family Liaison Officers before the IPCC are involved.

4.2.3 Role of the investigating bodies in signposting to independent advice and providing information about the investigation process

> '[I was] just told by a sergeant to get a solicitor for the inquest. No information or support at all. A friend found INQUEST on the internet and the organisation was excellent, just excellent providing invaluable information that helped enormously.' [Family of a young man who died following police pursuit]

Investigations into custody deaths can take from six months to over a year or longer, depending on the circumstances of the death. Investigations can be prolonged if the issues raised are complex or if referral of the case to the Crown Prosecution Service (CPS) occurs (most likely in police custody cases). This underlines the importance of ongoing information and support provision as the families will be engaged in the process for a protracted period.

In a PPO investigation, the first contact that a bereaved family will usually have will be when they are contacted by the Family Liaison Officer, which can take place up to 20 working days after the death has occurred. As discussed in chapter 3, unless the family have been signposted to where they can go for information and support in the interim, they may well have been left alone for a month, during which

16. *Making the new police complaints system work better,* 2005.
17. *Step by step: advice for friends and family,* 2005.

time the inquest will have been opened and adjourned and the body released for the funeral. Families have often expressed confusion and bewilderment as to what is happening at this early stage. Although they might have been told by the police or Prison Service that the death will be investigated by the PPO sometimes no-one has explained to them who and what this is and what the initials stand for. This can also make their initial communication with the PPO more difficult.

Good practice has been reported where the PPO Family Liaison Officer has established early contact, has left mobile phone contact details so a family can always get hold of the relevant person and has proactively encouraged families to contact INQUEST.

In our experience families have never complained of being overloaded with information either about where to obtain advice and support or about the procedures that follow the death – on the contrary complaints are always about the absence, limited or confusing nature of the information provided.

There are no published IPCC or PPO policies or protocols that provide guidance to their Commissioners, investigators or Family Liaison Managers/Officers on working with bereaved people. How a family is treated is dependent on the level of knowledge, understanding and approach of the individuals involved. This means families have experiences of differing quality and there is a lack of clarity about what they can expect. There is a need for training and clear protocols for those in direct contact with bereaved people that can ensure uniformity of service delivery in all areas.

Casework example

A family member searched the internet the night he was informed of the death of his brother and contacted INQUEST the next day. As a result he received immediate advice and support, and contact was made with the PPO on his behalf requesting an earlier meeting with the investigator than usual as the family was desperate to find out what had happened.

> 'Some information [was] given, but not nearly enough. Information given to me in writing by the Prisons and Probation Ombudsman was unsatisfactory in various ways … Overall, information given (or which should have been given) to me was either (a) ineffective, (b) inaccurate, or (c) not given at all.' [Family of a woman who died in prison]

> 'The INQUEST caseworker arranged our solicitor and explained things the Prison Service couldn't be bothered to.' [Family of a young man who died in a young offender institution]

4.3 Family contributions to the investigation process

Historically, one of the biggest complaints from bereaved families has been the failure to give them information about what would happen during the investigation. Over two thirds of families complained that they received no written information and insufficient explanation

about how the death would be investigated and how they could contribute. Again we emphasise the need for duplication of information in writing or for personal contact to be made to ensure their informed involvement.

> 'The family should be given information regarding the support available. After a suicide in prison a procedure should be followed. The prison and police should give support and facts.' [Family of a man who died in prison]

Material outlining their rights and the role that they can play should be distributed to the families at the very beginning of the investigation procedure. This should complement the more general information distributed by the Coroner's Court.

All investigations should follow an agreed basic protocol, set out and explained to a family both in writing and orally at the beginning of the investigation. Good practice is developing within the PPO and IPPC about the investigation process but the protocol would act as a reminder to the investigators so that families are kept up to date if there are any changes affecting the progress of the investigation. The process should not be reliant on the families having to initiate contact.

A letter should be sent to families at the earliest opportunity about the investigation process and what it will entail and where they can go for support and advice – including advice about funeral expenses and how to arrange receipt of the personal effects and belongings of the deceased. It should also outline family rights to legal representation and disclosure of information indicating proposed timescales in relation to the investigation and inquest process. Families and their lawyers have reported that timescales have been changed and families not informed or given an explanation why.

4.3.1 Role of Family Liaison Officers and Family Liaison Managers

The concept of family liaison developed as a result of the criticisms levelled at the police in the report of the Inquiry into the Death of Stephen Lawrence.[18] The development of this role has been primarily in the context of homicide investigations and other deaths that do not involve the conduct or actions of police officers. The role has not transferred smoothly into working with families bereaved by deaths in custody.

The role of the police Family Liaison Officer (FLO) in cases of deaths in custody has been that of an evidence gatherer, and a provider of information and support, with emphasis being on the former. This tension has given rise to families describing that they felt they were being investigated rather than the circumstances of their relative's death. Families bereaved by a death in custody may also have a history of involvement with the criminal justice system and an associated mistrust of state officials.

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18. *The Stephen Lawrence Inquiry,* 1999.

> 'My Liaison Officer was helpful to a certain degree but as she said, she was 'here to help but first and foremost she was a police officer' so I thought, she is here to gather information.' [Family of a man who died following contact with police]

> 'Police should, after asking about post mortem, if they are meant to be your family liaison officer, advise you properly! Was no help, no guidance to me at all only after what he could find out!' [Family of a man shot dead by police]

'At a recent inquest into a police shooting where I represented the bereaved family they complained to me about the conduct of their FLO. Information given to the FLO in confidence had been passed on to the coroner and all other parties including the police. This had been done without telling the family, getting their consent or discussing it with me.' [Barrister, London]

Despite work with some victims' family organisations[19], the role FLOs play in the aftermath of deaths in police custody is often confusing and at worst intrusive.

The Prison Service, the PPO and IPCC have adopted the model in relation to custody deaths and a FLO will also feature where there is a parallel criminal investigation into a death in prison. Where there is a death in police custody a FLO from the police force involved in the death will sometimes be appointed to the family; it has not always been made clear to the family what role this person is playing and to whom they are accountable. FLOs need a clearly delineated remit to avoid confusion about whether they perform an investigatory role.

"It has long been recognised that individuals who assume responsibility for liaison with the bereaved cannot simply rely on innate ability to approach the task sensitively. The consequences of poor liaison can be catastrophic not only for the relationship between the state agency and the bereaved but for the efficacy and quality of the investigation itself. Thus, training to a high standard is of central importance to an effective family liaison strategy." (The Deepcut Review)[20]

> 'Yes [we did receive support from a named Family Liaison Officer]. A police Liaison Officer called about five or six times. We did not find it very helpful as we were kept in the dark about the investigation.' [Family of a man who died in a police vehicle incident]

> 'We found [support from a FLO] very biased and lasted only up until the inquest. We were then told to get on with our lives.' [Family of a man who died in prison]

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19. We know that a number of organisations working with bereaved families have had input into FLO training but this has been limited to organisations where the death does not involve the state, for instance RoadPeace on road traffic related deaths or the Marchioness Families on major disasters.
20. *The Deepcut Review,* 'Annex C The Opinion of Fiona Murphy', 2006, pt 5.23, p14.

> 'There should be a totally independent organisation that is on hand to speak to families (if the families want to) [to] offer advice, support and keep them fully informed. Family Liaison attached to police are not helpful and not to be trusted.' [Family of a man shot dead by police]

Those in family liaison roles need to be trained to understand the specific needs and concerns of families bereaved by deaths in custody. The PPO and IPCC should train and support their FLOs and FLMs with input from those organisations working with such families.

4.3.2 Families' meetings with investigators

"The public/state imperative to 'investigate' expeditiously is fundamentally at odds with the private/family need to grieve, make funeral arrangements and engage with other post-death rituals." (Goldson and Coles)[21]

Investigations usually begin immediately after a custodial death at a time when the family will be experiencing all kinds of emotions: from profound grief to anger with state agencies, confusion over unclear lines of communication, and frustration. These feelings are often compounded by institutional insensitivity or misinformation. Families may also be experiencing feelings of guilt and a sense of shock and disbelief.

4.3.2 a Interviews with police/coroner's officers

Even if the death is being investigated by the IPCC or PPO the first contact families have with the investigation process could be an initial interview with the police and/or coroner's officer in the first few hours or days after it occurred. Families describe their reluctance and distress at being asked to provide a statement and background at such an early stage of the bereavement process. This is not only intrusive on their grief but will often mean they will not have had the opportunity to obtain legal representation. This contrasts sharply with the situation regarding police and prison officers where there can be considerable delay before an initial statement is taken or an interview happens.

'At a recent inquest during the questioning of firearms officers who had shot the deceased when asked why they had waited several days before making their first statement they responded that this was upon advice from the Police Federation and their lawyers due to the risk of 'perception distortion'.' [Barrister, London]

'Statements taken from them are quite brief, and normally a couple of days after the family members have died, when they've got a million things going on around them; other clients of mine have had the experience of the statement being taken when all the family are in the house. To take a statement at this stage is very unfair … it's only as time goes on that they stop to think.' [Solicitor, Blackburn]

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21. *In the care of the state?*, 2005, p83.

'They've always been taken within a day or so of the death when the person hasn't managed to formulate in their own mind all their concerns and worries and so on.' [Solicitor, Leeds]

Families need sensitive intervention that is informative and supportive and that recognises that bereaved people need time and space to grieve. Families who have contacted INQUEST at this very early stage have expressed their relief at finding the organisation. The value of early input in the first stages of bereavement means that they know their interests will be appropriately looked after by a lawyer who can initiate inquiries and liaise with the coroner and investigators while they deal with the emotional and practical consequences of the death. It has also assisted them in getting help with funeral costs and advice on the opening of the inquest.

> 'As soon as I spoke to INQUEST they arranged for me to see [a solicitor] who was wonderful. For the first time since my son died I felt someone was there for us and was listening and felt a whole weight lifted from my shoulders.' [Family of a young man who died in police custody]

In the immediate aftermath of the death there should greater understanding of the tension between the need to proceed with the investigation and the potential and actual intrusion into the human experience of the aftermath of sudden and unnatural death; this must inform practice.

4.3.2 b Interviews with investigators

Where there is an IPCC or PPO investigation there is usually an offer of a meeting with the investigators and Family Liaison Officer/Manager. We have been made aware that families have turned down the offer of a visit, which raises interesting questions as to why this is the case.

There is a lack of clarity about the status of meetings families have with the investigators. In some cases what families thought was a chat is subsequently viewed by the investigators as a formal interview. It is clear from the responses of families that there is confusion around the distinction between a meeting where the purpose is to involve the family in the investigation process by providing them with information and an interview where the objective is to gather information from the family.

> 'I was interviewed at my home with my mother present by [the Prison Service investigator]. I was not told that it was an interview and that my comments would be included in the report.' [Family of a man who died in prison]

> 'My father and brother travelled to Sussex when it first happened. We had to make our own travel arrangements. They were asked to give a family tree and talk about my brother and his lifestyle. They did not have any legal advice/advisor at the time.' [Family of a man shot dead by police]

Taking a statement from the family so soon after the death means that they are likely to be interviewed before they have legal representation and they not know why a statement is being taken.

'What I've tended to find is that they're interviewed quite quickly after the person has died as part of the police investigation or the PPO investigation and I've therefore not been there at the interview because they probably haven't instructed a legal representative at that early stage.' [Solicitor, London]

'Usually somebody from the family is interviewed, one or two, and usually before I'm instructed.' [Solicitor, London]

Families are often too distressed to meet the investigators, are mistrustful and unclear about the function of the meeting, who the people attending are and what their roles are in the investigation. Obviously this meeting can be an important opportunity for the family to be given information about what the initial investigation has revealed. It also provides them with an opportunity to raise their early concerns about the circumstances of the death.

Given the above, it greatly assists families to have their solicitor and/or an INQUEST case worker present at this initial meeting. The representative can help facilitate the meeting, keep a note of proceedings and of the initial information disclosed about the circumstances of death and how it is being investigated. Families report that it is difficult to remember what has been said at meetings and that it is helpful to have someone present who can help articulate their concerns and keep an accurate record of what was discussed.

If the IPCC/PPO want a statement from the family it is good practice to obtain one from the family solicitor. This should happen after more detailed information about the death has been provided to the family. A number of solicitors say they often prepare statements from the family for the inquest either to avoid the need for an interview altogether or to ensure that all of the relevant questions and information for the family are submitted to the investigation.

Clear demarcation is necessary between meetings at which the family are an equal stakeholder in the investigation process and interviews where the families are required to provide information to assist the investigation. Problems could be resolved if a clear, coherent and consistent national protocol for the structure of the relationship between the investigating officials and the bereaved existed.

The investigators need to be explicit about the purpose of their initial meeting with the family and should approach it as a two step process: first to provide families with information about themselves and the investigation process and second to obtain initial information from families about their relative in order to provide background to the investigation. There should be ongoing opportunities for families to update and add to this information.

Consideration should be given to ensuring that funding is available for families to attend meetings either with the investigators and/or

their lawyers otherwise their proper involvement in the investigation is hindered.

4.4 Access to information during the investigation

> 'We found the months following my son's death extremely upsetting and waited to have news of the reports etc that were being raised. We had NO contact with anyone at this time (one year). We have pushed for information only after being given a date for the inquest. This was such short notice to prepare anything. I feel very strongly that we should have been kept informed of all developments. We felt in the dark and constantly hitting a brick wall for information.' [Family of a man who died in prison]

4.4.1 Keeping families informed of progress

There is a legal obligation to keep families informed of the progress of the investigation. Families may ask that this is done through their lawyer. The PPO has no guidance on this but does give families the opportunity to contact their FLOs if they have any questions during the course of the investigation. However in our casework experience the majority of families heard very little from the PPO until the draft investigation report was completed unless they or their lawyer initiated contact. Where a family was legally represented there was more evidence of interim meetings and contact taking place during the course of the investigation. Where no lawyer is involved it is most common for the next contact to occur when the draft report is received through the post.

The IPCC statutory guidance states that contact on the progress of the investigation should be made every 28 days. But the quality and content of the information that is provided often falls short of the family's legitimate expectations (see section 4.4.2 below).

> 'Police only tell you what they want you to know. They could tell you more and the truth, but they only contact you when they want something. They try to be sympathetic, but it's only a job to them.' [Family of a man shot dead by police]

> 'We were kept informed but I had no access to documents until just before the inquest.' [Family of a woman who died in prison]

Half the families were of the opinion that they were not kept up to date and involved in the progress of the investigation. Of the others who felt that they had been involved and informed, many were dissatisfied because the information was inadequate, difficult to obtain or delayed. Informing families about progress is important but on its own is not sufficient. They need to be properly involved in the process and feel that they can contribute from an informed position.

> 'The investigation was totally inadequate. I was not involved at all. When a different force took over the investigation was totally different. I was classed as a 'living part' of the investigation and kept fully informed with letters of introduction and contact

telephone numbers.' [Family of a man who died in police custody]

'[We were] not expected to contribute. Just felt we were in the way.' [Family of a man who died in prison]

'[I] received a letter from the Senior Investigating Officer to advise [me that] an investigation was to be carried out. I was not asked to contribute or to be involved.' [Family of a woman who died in prison]

Consideration also needs to be given to facilitating a meeting with a senior representative of the institution concerned if the family wishes.

'As regards the investigation, I found it very important (but that is my own personal view) that I should be met by a senior officer from the force concerned. I never met any senior officer. It felt to me as if my son's death was not important to them.' [Family of a man who died in police custody]

4.4.2 Release of documentary information

Pre-inquest disclosure of information held by state agencies to bereaved families is fundamental to ensuring a death in custody is properly investigated. If it is only the state institution that has sight of the documentary evidence families cannot bring their perspective to bear on the investigation and ensure additional avenues of enquiry are pursued.

Historically the issue has been surrounded by controversy. For a family trying to engage in the investigation the state's reluctance to provide early and full disclosure fosters suspicion and mistrust, and is alienating and unhelpful.

What most families want, and what they understand being informed about progress in the investigation to mean, is that they will be told about what has occurred and be given documents relevant to the investigation which they can consider.

Currently practice varies according to the complexity of the case, the relationship that is built up with the investigator, whether the family is represented and the quality of the representation. Obtaining disclosure of documentation is a complex and time consuming task even for the most experienced lawyers. Therefore practice remains inconsistent and variable.

There is no IPCC protocol on disclosure of the draft investigation report. There are also additional barriers to disclosure in deaths in police custody because of the way the IPCC is obliged to operate under the Police Reform Act 2002. In independent or managed investigations the IPCC must

Casework example

Following the death of a child in a secure training centre, there was an appalling delay by the Youth Justice Board in conducting an investigation and it was subsequently taken over by the PPO. Their investigation was greatly assisted by the family and their solicitor being able to play a meaningful part from the outset with ongoing communication during the process. The end result was an extremely thorough and informed investigation that addressed many of the family's concerns.

refer a case to the CPS if the investigation indicates that a criminal offence may have been committed, even if there is not sufficient evidence in their view to prosecute. The consequence is that the conclusion of the investigation is delayed, the family may think that there is a real possibility of a prosecution, and they and their representatives do not have access to the documentary evidence. Their opportunity to participate in the investigation is extremely limited and the inquest process seriously delayed.

In these cases the disclosure of evidence by the IPCC is largely limited to summaries of the evidence generated by the investigation. These summaries are always from the perspective of the IPCC.

There is a protocol on disclosure in PPO investigations and where a lawyer is involved the family will be asked how they would like to receive the report. In most cases the draft report only is given to the family and their representative and they do not receive the other documents relevant to or generated by the investigation, for example the appendices, guidelines or policies and procedures operating within an individual prison or across the Prison Service. It is only where the family have an experienced lawyer that they will have access to this material.

Casework example

The mother of a child who had died in custody found it too distressing and emotionally overwhelming to read all of the draft report and documents that had been disclosed to her. Her legal team were able to reassure her that she did not have to go through the report. They would do this and relay to her the key issues emerging and get instructions from the mother about her concerns. She was incredibly relieved by this. This highlights the solicitor's role in minimising additional stress but also facilitating the participation of the family in the investigation.

"For disclosure to the family to support real and effective participation in the inquiry, as required by Article 2, it must be thorough, prompt and affordable. We recommend that the fullest possible disclosure should be made to the family well in advance of the inquest." (Parliamentary JCHR)[22]

'[There should be] a totally independent investigation; transparent family access to documents; [family] privy to final report before it is passed to the CPS; and humanity.' [Family of a man who died following contact with police]

Receiving a copy of the draft report is crucial and families need time and resources to have meaningful input into the final report via their lawyer or on their own. A subsequent meeting with the investigators may help their views be heard. In any event families' input at

Casework example

The family were critical of the delay in completion of the investigation report because the investigator had been called away on another death. They were concerned that they were not being kept fully informed of the reasons for the delay and what matters were outstanding in terms of needing investigation or reinvestigation.

22. *Deaths in Custody: Third Report of Session 2004-05 Vol I* , 2004, para 302, p86 .

this stage serves to raise any issues they feel have not been explored or that they would like further examined.

Families should be given a choice as to how they receive information that is gathered as part of the investigation. They should be informed about the investigation irrespective of whether they are involved with it and given adequate time to absorb its findings and raise concerns about the draft report.

Casework example

The PPO began to investigate a death in prison. However the coroner then requested that the CPS review the file. As a result the PPO suspended their investigation and the family was not notified that they had done so. It was only after INQUEST intervened that they received a call from the PPO to explain what was happening.

4.4.3 Delays in completing the draft report

The time taken to complete PPO investigations varies depending on the complexity of the case and on whether any issues need to be further investigated following comments on the draft report. In some cases there can be considerable delay.

> 'Information took far, far too long to come through. Some interviews (post-death) were done months after my husband died and likely to be inaccurate. The nine months to get the prison report and 12 and a half months to get the police report were NOT acceptable – the delays caused even greater upset.' [Family of a man who died in prison]

> '[There was an] unacceptable delay and inappropriate language to explain it. The Ombudsman said that the suspected delay was due to 'a quality control issue with a commissioning agent.' I was not impressed with his answer, which sounded like 'Home Office speak'. Use of such jargon is unacceptable when speaking to a grieving mother.' [Family of a woman who died in prison]

> '[I expected] the full facts surrounding my husband's death to be uncovered in a realistic timescale (six months). Instead it has taken thirteen months to set a date. I have been periodically upset as more sensitive information is gradually released. Prison report was received May 2004! Police report was received July 2004!' [death occurred in August 2003] [Family of a man who died in prison]

Some of this is clearly due to lack of resources – with investigators being called away to begin another investigation – and unrealistic expectations regarding the time it will take to complete the report. Sometimes delays will be unavoidable but it is not acceptable to neglect to keep the family informed of the cause of the delay and the expected timescale for its resolution.

However in some cases completing the draft PPO report and handing it to the coroner has been held up for bureaucratic

Casework example

Following the death of a child in a secure training centre the police were called in to investigate. Over two years since the death, and six months after the CPS decision not to prosecute, the family had still not received the police investigation report. They had no opportunity to participate in any of the investigations following his death.

reasons that should not delay the inquest and public scrutiny of the death. The question arises about who has the authority to insist that the investigation and report are completed.

4.4.4 The final investigation report

The final investigation report is highly significant for a bereaved family. Part of its purpose is to answer their questions and concerns, as well as carrying out its public function of identifying systemic or individual failings of the system in which the death took place.

Prior to the PPO and IPCC taking over the investigation of deaths in custody, families described serious difficulties in obtaining a copy of the report:

> 'The coroner initially refused. I had to personally ask him whose side he was on before I could see the report.' [Family of a young man who died following police pursuit]

> 'I only got a letter [and that was] because I harangued the Home Secretary.' [Family of a young woman who died following contact with police]

> 'I have been told the outstanding reports are the property of the police.' [Family of a man shot dead by police]

Although the situation has improved, serious delays still occur. Provision of the investigation report to the family should be mandatory. There can be no good reason why a family is unable to read the formal explanation for the death of their relative.

> 'Yes [I did receive a copy of the report]. Yes [there were problems] – delay. Sensitive information was withheld from me. The past year was terrible as more and more information was gradually revealed to me: even more upsetting.' [Family of a man who died in prison]

4.4.4 a Status of final reports

Following the conclusion of the investigation, both the PPO and IPPC treat their reports as the final outcome of the investigation. However, reports form the basis of inquests and neither the PPO nor the IPPC amend their reports to take into account any information or issues that emerge at the inquest.

This is compounded by PPO's role in the inquest. Unless the coroner decides to call the investigator to give evidence, the PPO is unlikely to have a presence there. They are not routinely informed about when an inquest will take place. They do not monitor the outcome of the inquest, jury recommendations, or any rule 43[23] comments or findings by the coroner. Their report is eventually placed in anonymised format on their website, but will not reflect inquest evidence, the jury findings nor any recommendations following use of rule 43 reports.

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23. See chapter five 5.4.1.e.

Although the IPCC have a more proactive role in relation to the inquest – at least having someone present or in some cases being legally represented – they also have limited and undeveloped mechanisms for ensuring that information that emerges from the inquest is given formal consideration.

In our view the report can only be viewed as a draft until the completion of the inquest as it is only there that the report will be scrutinised and the evidence gathered tested through the examination of witnesses. The inquest is an important forum in which the quality of the investigation and its findings and recommendations can be subjected to scrutiny, thereby informing the investigation bodies' future conduct of investigations.

Investigation reports should be updated following the inquest to take into account inquest evidence, jury findings and any coroner's comments or rule 43 reports. It is vital that this is done before reports are made public on websites or elsewhere. The reports should then be published and the IPCC and PPO should use them to both promote better practice and to monitor the response of the relevant authorities to any investigation or inquest findings.

4.5 Concluding remarks and recommendations

For the investigation and inquest system to fulfil the needs of families, to be compliant with human rights law and to fulfil a wider civic role, justice not only needs to be done, it needs to be seen to be done. This can only be achieved if families are able to participate effectively in the process from an informed position.

A bereaved family can provide context and understanding about their loved one's life to the inquest and an alternative account which challenges that of the state. Families still contact INQUEST in some distress following deaths in prison and police custody after a difficult search to find the organisation some weeks or months after a death. Although there have been examples of good practice by those involved in the new investigation models through actively encouraging families to seek legal advice and independent support, there is still great inconsistency of approach.

It is still the opinion of many families that the investigation was a whitewash, intended to protect the institution in whose custody the deceased was at the time they died, rather than completed with the intention of ascertaining objectively how the deceased died, why they died and whether state agents were implicated in the death directly or indirectly. Given the context in which these deaths occur this opinion is not unreasonable and it underlines how important it is for the new investigators to understand what is at stake. Learning from and listening to what has gone wrong in the past can guide and inform current practice.

Some families have assumed that 'independent' means that the investigation is being carried out on their behalf. The investigating bodies need to recognise that the expectations of the families are

going to be very different from those of the state institutions involved.

The new processes are evolving. Experiences of the previous processes described by families are important indicators of what can go wrong and how damaging the consequences can be. In any new process there will be initial problems. The reformed system needs to be open and prepared to face the challenges and difficulties that may arise and to review, revise and develop new policies and procedures if necessary. It is important that the same flawed culture and systemic failings that undermined public confidence in the past is not recreated. In writing this report we have identified worrying examples of the way families have been treated that are reminiscent of previous discredited practices. Without a thorough awareness and honest examination of the past problems and what caused them it is not possible for a new system to avoid the same bad practices.

Recommendations

The Investigation

9. The Independent Police Complaints Commission and the Prisons and Probation Ombudsman must:

a. recognise that the expectations of families are very different from those of the state institutions involved;
b. understand that in the immediate aftermath of the death there can be tension between the need to proceed with the investigation and the potential and actual intrusion into the human experience of the aftermath of a sudden and unnatural death;
c. put in place clear, coherent and consistent national protocols for the structure of the relationship between the investigating officials and all others in direct contact with bereaved people;
d. ensure that investigations follow an agreed basic protocol;
e. ensure investigators are explicit about the purpose of their initial meeting with the family and approach it as a two step process: first to provide families with information about themselves and the investigation process and second to get information from families about their relative to provide background to the investigation;
f. complete investigations within agreed time limits;
g. offer a meeting with the family and their lawyer to discuss the investigation report;
h. update investigation reports following the inquest to take into account inquest evidence, jury findings and any coroner's comments or rule 43 reports prior to publication;
i. publish the reports and the authorities' responses to them;
j. use the reports and findings both to inform subsequent investigations and to promote better practice.

10. IPCC Commissioners, PPO managers, all investigators and Family Liaison Officers and Family Liaison Managers should:

a. receive training on the specific needs and concerns of families bereaved by deaths in custody;
b. receive such training with specific input from those organisations working with such families;
c. ensure there is clear demarcation between meetings at which the family are an equal stakeholder and interviews where the families are required to provide information to assist the investigation process.

11. Bereaved families should be entitled to:

a. an oral explanation of and a letter about the investigation process from its beginning outlining their rights and the role that they can play including reference to legal representation, proposed timescales for disclosure of information and completion of the investigation, sources of support and advice including information about INQUEST, advice on funerals, expenses, etc;
b. clear explanations about the purpose of any meetings;
c. funding to enable them to attend meetings with the investigators and/or their lawyers;
d. information about progress of and full involvement in the process;
e. a choice as to how they receive information gathered as part of the investigation;
f. receive information about the investigation irrespective of whether they are involved in it or not;
g. adequate time to absorb findings of the investigation in order to raise any concerns they might have about the draft report;
h. mandatory disclosure of the investigation report.

Chapter 5: The Inquest

"Inquests are too often at risk ... of being opportunities for official and sanitised versions of deaths to be given judicial approval – rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one." (Coles and Shaw)[1]

"Inquests are the only legal proceedings where the involvement of a party will be almost entirely involuntary.… Only at an inquest is the hearing necessary for a family to find out how the death of their relative was caused and whether any public authority was in any way responsible for the death. They could of course choose to be indifferent to their right to participate in the process, but such a choice cannot be factored into any justifiable argument as to why families should not be properly funded for choosing to take up the right of knowing how and why a relative has died." (Thomas et al)[2]

"Under the current coroner service, families frequently get overlooked during the inquest process. There is nowhere for them to turn when they think that something is going wrong; there is no complaints system. The system is fragmented, with no national leadership, and it is not accountable. We have no overview of the system as a whole, or of individual cases. Moreover, the system is not properly accountable to this House, which it should be. Standards are not uniformly good; everything rests too much on the personal qualities and abilities of individuals within the system. The legal framework is downright archaic… The coroner service must serve the public interest and meet bereaved families' concerns in a way that, frankly, it currently does not." (Harriet Harman QC MP, Minister of State)[3]

5.0 Introduction

In this chapter we discuss families' experiences of the inquest hearing. We explain how the inquest system works and examine the law and procedures that govern the hearings. We outline the problems families face and make suggestions for better practice. We look at the issues that arise following the conclusion of the investigation and in preparation for the inquest hearing; we discuss the experience of the hearing itself and what happens after it is over. We present families' perceptions of the whole process and the views of the lawyers who represent them.

"When someone dies a violent or sudden death … there must, in the public interest, be a proper inquiry and the bereaved relatives need to know what happened and why." (Harriet Harman QC MP)[4]

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1. *How the inquest system fails bereaved people*, 2002, p5.
2. *Inquests: a practitioners guide*, 2002, para 11.1, p120.
3. *House of Commons Hansard*, debates for 6 Feb 2006, column 607.
4. *Hansard*, Feb 6 *op cit.*

It is accepted that custodial deaths should be subjected to public and judicial scrutiny and that there should be public inquests into all deaths in detention – deaths that involve the police, prison, immigration and psychiatric detention. We argue that these cases merit a specialist approach both in relation to the resources available to all involved and to the experience and expertise of the coroner presiding over the public inquest hearing.

5.1 Coroners Rules and human rights standards

5.1.1 Procedure

The functions of the Coroners Court have been narrowly defined until recently.[5]

All inquests are governed by the Coroners Act (CA) 1988 and the Coroners Rules (CR) 1984. In relation to deaths in detention, the CA provides that there must be an inquest held in front of a jury when:
a) the death occurred in prison or in such circumstances as to require an inquest under any Act other than the Coroners Act 1988;
b) the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty.

The CA does not provide for an inquest to be held with a jury where the death is of a detained patient, of a child imprisoned in a secure training centre or of a detainee in an immigration detention centre, although the approach of coroners is normally to treat such cases as requiring a jury.

The CA (s11) and CR (r36) provide that proceedings and evidence at an inquest should be directed towards answering four questions:
1. who the deceased was;
2. where the deceased came by their death;
3. when the deceased came by their death;
4. how the deceased came by their death.

The inquest does not provide for an exploration of all the facts surrounding a death. As discussed in chapter 2 it addresses the 'how' i.e. the physical means by which the person came by their death, rather than why they died.

Despite recent changes to the law, inquests do not fully explore issues of procedure and policy. Deaths are considered in isolation from one another without an overview of the systemic factors which may have contributed to a pattern of similar deaths. The findings of previous inquests or inquiries into deaths involving similar factors or deaths within the same institution are very often not considered.

Some coroners have embraced the changing culture created by case law and imminent reform and agreed that some broader policy

5. The judgment in the *Middleton* case (2004) significantly altered the conduct and remit of inquests into deaths that engage article 2 of the Human Rights Act 1998. (See chapter 2 and below for discussion).

questions are legitimate lines of inquiry during their inquests. By contrast there are others who refuse to let juries consider narrative verdicts in cases of deaths in custody, do not understand or have any awareness of the good practice that has developed in directing juries to return these verdicts and operate as though there has been and will be no change.

For the family the inquest can be both confusing and unsatisfactory. This is their chance to find out what happened and usually the only opportunity for public scrutiny of the death. Families are often perplexed by the narrow definition of 'how' and shocked to discover the limits of the issues that will be discussed: many see systemic failings as contributing to their relative's death and want the court to look more closely at the underlying events or examine similar deaths.

Families may be surprised to discover that inquests are inquisitorial 'fact finding' exercises as distinct from adversarial processes designed to apportion responsibility, liability, blame and/or guilt. Often families' only experience of courts will have been of the adversarial kind so they find the inquisitorial concept strange, particularly when they see teams of lawyers representing the detaining authorities. There is frustration at the lack of accountability for their relative's death. This is particularly acute in the small number of cases where the Crown Prosecution Service has considered whether anyone should face criminal charges in relation to the death. Families in these circumstances feel that there should be a trial and yet the death is examined in the Coroners Court.

The narrow focus and restricted nature of inquests is underlined by rules 36 and 42 of the CR 1984 that state:

"Neither the coroner nor the jury shall express any opinion on any other Matters" (r36(2)).

and:

"No verdict shall be framed in such a way as to appear to determine any question of:

(a) criminal liability on the part of the named person, or

(b) civil liability" (r42).

There are no parties but properly interested persons; no formal charges or pleadings at inquests but discussion and argument about the evidence; and no cross-examination of witnesses, rather questioning to elicit information that will help to establish the facts. The coroner's role is to "fully and fearlessly"[6] examine the circumstances of the death in order to establish a factual account. Witnesses are called to give evidence for the purposes of determining where, when and how the person died. The role of all legal representatives is to assist the coroner in carrying out that task.

6. *R v North Humberside Coroner ex parte Jamieson* [1995].

5.1.2 Recent legal developments

As Goldson and Coles have argued, the situation prior to *Middleton* meant that "the narrow confines within which inquests operate are, in effect, prohibitive: they can serve to conceal more than they reveal in respect of the broader circumstances within which … deaths in … custody are located."[7]

It has also been noted that "the procedural obligation introduced by article 2 has three interlocking aims: to minimise the risk of future like deaths; to give the beginnings of justice to the bereaved; and to assuage the anxieties of the public."[8]

During the 1980s and 1990s, and even after the implementation of the Human Rights Act 1998 in 2000, there was extensive legal argument about the meaning of the word 'how'. Debate covered the nature and extent of pre-inquest disclosure, the use of expert evidence, the introduction of evidence concerning training and other procedures, the jury's findings, and the coroner's powers to report action that should be taken to prevent the recurrence of similar fatalities under rule 43 of the Coroners Rules 1984.

As discussed in chapter 2 'how' is now to be interpreted more broadly as 'by what means and in what circumstances'. Inquests into deaths in custody that engage article 2 should now proceed without such extensive legal argument over this issue. In theory, the inquest should be more consistently meaningful for bereaved families because its scope and its conclusions can now reflect the evidence more fully. However, in order for meaningful involvement to be achieved, accompanying changes are needed in relation to pre-inquest disclosure (see paragraph 5.3.2 a, and previous chapter); pre-inquest meetings (see 5.3.2 b), the nature of evidence to be heard (including the expanding role of expert evidence) and public funding for legal representation (see 5.3.1 b).[9]

Middleton has important implications for the expression of the verdict at these inquests, with the House of Lords finding that:

"An ... inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case ... such as an expanded form of conclusion as to death, a narrative verdict, or by inviting answers to specific questions."[10]

The Lords also found that the duty to investigate extends to drawing conclusions from the investigation and inquest evidence as to "the accountability of the State for the death."[11] The *Middleton* judgment means that this is now possible in relation to deaths in

7. *In the care of the State?*, 2005, p 83.
8. *R v Secretary of State for Health ex parte Khan* [2004] at 67(3)
9. By representation we mean both instructing a solicitor shortly after the death for the duration of the investigation and inquest and a barrister or solicitor for the full hearing.
10. *R v West Somerset Coroner ex parte Middleton* [2004]
11. *Putting Middleton and Sacker into Practice*, 2004, p2.

custody: juries are often invited to consider the option of a narrative verdict albeit usually at inquests where the family has experienced lawyers.

5.2 Structural problems

5.2.1 Administrative issues

The legal and administrative standards of the coroner service do not uniformly reflect modern concerns about legal processes or the rights of those participating in legal proceedings. Elsewhere, thought has been given and changes made to available facilities, e.g. the quality of courts and provision of witness and victim support. Coroners Courts have been ignored and remain largely outside the rights-based approach now generally applicable to other public functions and services.

The paucity of information provided to bereaved families about their rights in relation to the inquest and investigation process (as documented in chapters 3 and 4) is one example. Bereaved families can arrive at the inquest unprepared and its formality takes them by surprise. Sometimes they may have been told by the coroner's officers that they do not need a lawyer (see chapter 3) and find themselves facing an unfamiliar court room filled with experts and the legal counsel of other interested persons where they are expected to represent themselves during a complicated, distressing and specialised process. Families of people who have died in detention should not be given the impression that the inquest is informal and led to believe that they could ask the questions themselves.

Inquests can be held in a range of venues. We have attended inquests held in Magistrates Courts, in Crown Courts, in council chambers, as well as purpose built Coroners Courts. Many Coroners Courts are not modernised and very small – not really suitable for any inquest and not at all suited to more complex cases. In some jurisdictions there is no dedicated Coroners Court and the coroner's office is located within a police station, where anyone phoning the office calls the police station in the first instance and is then put through to the coroner's office. This can be particularly difficult for families bereaved by a death in police custody and raises questions about the independence of the service. This is compounded by the fact that outside large cities many coroner's officers are seconded police officers.

Minimum standards of facilities should be present in buildings in which it is deemed acceptable to hold inquests and locate coroner's offices. These standards should be set out in the coroner's charter.

Coroners Courts are frequently in particularly remote or badly served areas. Many have no refreshment facilities. Such basic practical oversights can adversely affect families:

> 'The police had lunch laid on while we had to take ours with us or walk into town.' [Family of a man who died in police custody]

The variable quality of courts means that there may be no private waiting area for families to sit during breaks or whilst consulting their legal team.

> 'We had to talk and wait in the corridor.' [Family of a woman who died in prison]

Lack of private space has been particularly distressing for families where they have had to wait or discuss their case in close proximity to people who they believe may have been responsible for the death. We would suggest that the coroner service needs to be 'rebalanced in favour of the victim' to ensure that families have the privacy they need.

Lack of space in general is also a problem. Inquests into deaths in custody often involve legal representatives for various interested persons and many files of disclosed documentary evidence, and there is often not enough physical space for the documents, individual legal representatives, and interested persons. The court space should be sufficient to comfortably accommodate everyone.

Lack of access to office facilities (phone, fax, internet, photocopying) has been an issue. In many inquests into custody deaths, interested persons from the institutions and those who represent them have had direct access to the court offices as if they were their own, while the families and their counsel are provided with few or no resources. This contributes to the perception of institutional bias and hinders the families' involvement. In the new coroner service all legal representatives should have access to the technology they need.

There is inconsistency regarding the transcription of proceedings. Some Courts have the resources in complex high profile cases to provide contemporaneous transcripts while others lack taping facilities for later transcription. Some still rely on the coroner's hand-written notes. Access to accurate transcriptions allows a family to consider the day's proceedings with their lawyer and helps reassure them in case of misremembered or misunderstood statements; it enables them to discuss what the evidence means and what questions are going to be asked the next day. It also enables proper examination of the proceedings should the outcome be challenged at a later date by any of the interested persons. There should be a standardised approach to recording proceedings and provision of transcripts; the cost should be met by the state.

There is wide variation in the quality of preparation of court bundles of documents. Poorly prepared court bundles can have serious adverse effects on the professional conduct of the inquest. Neat chronologically ordered sets of documents should be prepared for all of the interested persons. Relevant documents should be collated and numbered to enable everyone to work from the same bundle at the hearing.

'If we proceeded with disclosure lists and then a process of agreeing what should go in the core bundles and supplementary bundles and a

bit of colour co-ordination, we could be saying to witnesses, 'if you could take the red volume': [then] cross examination could proceed with rapidity. At the moment there is an awful lot that is contrary to common sense.' [Solicitor, London]

5.2.2 Structure of the coroner service

There is no national coroner service. Coroners are individual judicial officers with local jurisdiction, appointed formally by the Lord Chancellor and funded and appointed in practice by the relevant local authority. They have no national hierarchy; all have equal status and sit at inquests by virtue of the death occurring in their geographical jurisdiction. The rules of coroner's jurisdiction currently prevent the hearing of complex cases before specialist coroners: there is then a wide variation in approach dependent on geographical area.

Legal knowledge and understanding amongst coroners is variable with no system for ensuring they are all aware of relevant legal and policy developments, particularly in relation to their conduct of inquests into deaths in detention. In complex cases, coroners may lack the necessary skills and experience to conduct the inquest to the required standard. Coroners may be unaware of recent developments in case law and its application, or of national policy developments relevant to individual custodial deaths – for example, guidelines on restraint or suicide prevention. Or they may not have been provided with all the relevant disclosure by the detaining authorities because they did not know what to request.

'Police restraint deaths are not common and each case arises in a different jurisdiction. A coroner may only ever deal with one police restraint death in their whole career. Therefore there is no accumulation of expertise.' [INQUEST caseworkers]

A number of coroners have said how useful the publication *Inquest Law*[12] is for informing them about leading cases, their application in practice and developments in policy and procedure relating to deaths in custody. They feel it complements the briefings they receive from the Department for Constitutional Affairs and the Coroners' Society.

'They're [coroners] not always up to date about directions in law, on article 2.' [Barrister, Manchester]

'I did a case last year where the deputy coroner ended up dealing with the case and misdirected the jury straightaway. Counsel had to make submissions on Middleton and Sacker *and the coroner hadn't heard about them. It was a very distressing case and it had to be adjourned to enable the coroner to read the case because he wasn't up to speed on the law.'* [Solicitor, Leeds]

Coroners have no mandatory training or continuing professional development, are subject to no formal complaints procedure, and

12. *Inquest Law* is the journal of the INQUEST Lawyers Group and is published three times a year.

there is no requirement to belong to the voluntary Coroners' Society. The latter does try to assist with training and information exchange. Good practice is dependent on the approach of individuals rather than on agreed and inspected quality standards. Without a national coroner service there is no clear accountability. There is no national career structure, formal support and training for coroner's officers.

> 'The system needs radically updating. In my area, the coroner got the job because her father was coroner before her and before that another member of the family!' [Family of a young man who died in police custody]

In some cases legal errors in conducting the inquest have resulted in challenges by way of judicial review in the High Court. Whilst this clarifies the law, it is unsatisfactory for the family as it prolongs their engagement with the system. It is also impossible for most families to challenge a decision in this way unless they are eligible for full legal aid.

Coroners lack adequate resources and sufficient powers to be truly independent and depend on external investigations to shape their inquests. This reinforces the need for family lawyers to assist the coroner to determine the scope of the inquest and whether there is a need for any further investigation or independent expert evidence.

'*Coroners rely too much upon the Prisons and Probation Ombudsman, or the police or the Home Office to do their inquiry which then forms the basis of the inquest.*' [Solicitor, London]

'*There's a general under-resourcing of the coroner system. Often coroners are asked to investigate quite difficult issues without the resources to do it properly. Experts are often unfunded and sometimes difficult to get hold of.*' [Barrister, London]

In a reformed system core competencies should be set for all coroners and all should be required and properly resourced to attend regular professional training. In the short term complex and controversial custody death inquests could be heard before a judge sitting as a coroner. The national service should have a regional structure with the regional coroner having sufficient experience and knowledge to preside over all deaths in detention cases. A new national coroner service must be properly resourced to deliver a professional service comparable with other court services.

Many of the problems are attributable to the lack of procedure, structure and resources within the current system, resulting in tremendous variation in approach and lack of consistency between coroners. During the period covered by this report there have been both legal and policy changes that have affected the conduct of inquests, but their implementation is inconsistent. As the inquest is the only public forum in which these deaths are subjected to any scrutiny and where systemic failings can be exposed this approach must be changed.

5.2.3 Delay

"Where the inquest is the means by which the Article 2 duty of investigation is satisfied following a death in custody, then significant delays may breach Article 2, which requires that an investigation into a death be prompt. We are concerned that current delays may in some instances lead to breaches of Article 2." (Parliamentary JCHR)[13]

'We emphasise the need for the reviews of the coronial system... to address delays in the system'. (Parliamentary JCHR)[14]

"The Government shares the concern expressed here about the delays in the holding of some inquests. …There have been some cases where delay is unacceptable; work is underway to ensure these backlogs are tackled and reduced." (Government Response March 2005)[15]

> 'It is now over two years since my daughter's untimely death and the family have been deeply concerned over the period that has elapsed prior to the inquest being held. This has been a very traumatic time for all of us. We hope the inquest will explore our belief that those who were entrusted with [our daughter's] care did not apply the full duty of care that she was entitled to. We want to know if her right to life could have been more adequately safeguarded with proper consideration to, and management of, her vulnerability.' [Father speaking at the opening of the inquest into the death of his daughter in prison]

'It is highly regrettable that two more women have had to die in this prison before the women's wing was finally closed in September 2005 despite the earlier recommendations by the Chief Inspector of Prisons.' [Solicitor, Leeds]

> 'It is nearly two years since my daughter died. The long wait for the inquest into her death has been an ordeal for all the family. I have many questions about the circumstances surrounding my daughter's death and I hope to get some answers.' [Family of a young woman who died in prison]

> 'We have waited nearly five years for an inquest, that's too long.' [Family of a young woman who died in prison]

Delay in completing the inquiries after deaths in custody is one of the most serious issues that needs to be addressed – not only because of the impact it has on bereaved families (see chapter 6) but because of the effect on all involved in the aftermath of a death, and on public confidence in the credibility of the whole system. Delays of one or two years between the death and inquest are not uncommon (see Tables 3-6

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13. *Deaths in Custody: Third Report of Session 2004-05 Vol I,* 2004, para 304, p87.
14. *Ibid.*
15. *Government Response to the Third Report from the Committee: Deaths in Custody: Eleventh Report of Session 2004-05, 2005*, para 304, p49.

below) and two recent inquests have been held into deaths in prison which had been outstanding for five and nearly six years respectively.[16]

The lack of timely public scrutiny of the circumstances of the death undermines the preventative potential of the coronial process and the ability of the coroner to report matters of concern to the relevant authorities and play a monitoring role in looking at standards of custodial care.

After such delay it is not unusual for witnesses at the inquest to have difficulty in recalling the detail of events and the policies to which they were working at the time. At a recent inquest into a death in prison there was confusion amongst prison officers about which protocols on bullying applied as they had been updated a number of times since the death. Witnesses may have left the institution and not be traceable and the same may apply in deaths in prison to prisoners who may have important evidence to give. Institutions then respond to concerns arising at the inquest by asserting that changes have subsequently been made but this cannot be tested in evidence at the inquest. Coroners are thus effectively discouraged from using their power under CR r43 to report matters of concern and where they do so both their report and any media coverage of the inquest can be dismissed by the detaining institutions as out of date.

Casework example

Two years after the death of her 15 year old son in a secure training centre his mother had received no information whatsoever from the investigation into the circumstances of her child's death.

Delays also frustrate the learning process where individual or systemic issues remain unaddressed pending the inquest.

'As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.' (INQUEST)[17]

While thorough investigations take time to complete the current situation is unacceptable for all concerned. The pressure on the system is evident well before completion of the investigation, with the shortage of suitably qualified forensic pathologists and other experts delaying completion of the forensic examinations, and the lack of resources and other issues contributing to the delay in completing investigations by the PPO/IPCC.

Additionally the current rules relating to coroner's jurisdiction mean that some coroners are disproportionately burdened with complex cases by virtue of the number of prisons or other institutions of detention in their geographical area.

For example, consider the Durham and West Yorkshire (Eastern District):

16. Ann Marie Bates died in HMP Brockhill August 2001 – inquest held June 2006; Adrian Longley died December 2000 in HMP Bullingdon – inquest held June 2006.
17. *Deaths in Custody: Third Report of Session 2004-05 Vol II*, 2004, Ev 144.

The Durham Coroner has the following prisons in his jurisdiction:
HMP Durham,
HMP Frankland,
HMP Low Newton,
HMYOI Deerbolt, and
Hassockfield Secure Training Centre.

The West Yorkshire (Eastern District) Coroner has:
HMP Leeds,
HMP New Hall,
HMP Wakefield,
HMP Wealstun, and
HMYOI Wetherby;

He also has in his jurisdiction the largest teaching hospital in Europe and Newton Lodge Secure Unit.

The total number of deaths from all causes in prison or secure training centres per jurisdiction during 2000-2005 was 50 (Durham) and 65 (W. Yorks). These break down as follows:

Jurisdiction	Self-inflicted	Non-self-inflicted	Other
Durham	21	29	0
W. Yorks	35	29	1 (homicide)

During the period 2000-2005, HMPs Durham, Wakefield, Leeds and Frankland were second, (joint) third, fourth and (joint) fifth respectively for the highest number of deaths per prison establishment in England and Wales.[18]

Inquests into deaths in custody have to meet the requirements of the *Middleton* judgment which means that the inquests take longer than before. In some areas the inquests need to be held in other courts or public buildings because of the inadequacy of the Coroners Court available, with coroners having to negotiate with the other users of those spaces. This adds further pressure on coroners' limited resources.

The problem affects not just the conduct of the inquests we focus on in this report but many other cases. Most recently the government provided additional resources to assist the Oxfordshire coroner with the delay in the holding of the inquests into many of the deaths of military personnel in Iraq.[19] This approach has not been adopted in any other circumstances.

5.2.3 a Effect of delay on families

Delay not only hampers the extent to which remedial action might be applied; it is also incompatible with the provisions of the Human Rights Act. It obscures the search for truth and, perhaps most significantly, it is utterly inhumane as it serves to prolong and intensify the pain for the family.

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18. INQUEST monitoring.
19. Statement on Oxfordshire Inquests by the Minister of State, Department for Constitutional Affairs, Harriet Harman QC MP. *House Of Commons Hansard*, written ministerial statements for 5 June 2006 column 4WS.

Finding out how someone has died in custody is an essential part of the bereavement process and yet for many families this is profoundly hampered by bureaucratic delay (Home Office Research Study 241). [20] Families describe their lives as being on hold until they have been through the inquest process (see chapter 6). Many families bereaved by deaths in custody are isolated and feel stigmatised by the nature of the death, finding it hard to discuss their concerns with those around them and living with the delay in finding out how a relative died is often detrimental to their physical and mental health.[21]

> 'After fighting for two and a half years to get a thorough inquest we are all totally drained. Our health is still suffering, I feel constantly exhausted, my eldest daughter has had many minor illnesses. My youngest daughter has had glandular fever for eight months – all because we are all at a low. It is a long hard battle and not finished yet. The inquest seemed to be the biggest hurdle for all of us; a lot of time and dedication and heartache went into that courtroom.' [Family of a man who died in police custody]

> 'I have been told the inquest may take three weeks and that I will have to give evidence in front of a jury in London. I am very stressed. There is no certainty about the date which is already extremely delayed.' [Family of a man shot dead by police]

> 'I think the time they take to sort out deaths in an institution is a disgrace, a part of you dies with your child, the emptiness goes on for a long time deep down without having the added depression of so many unanswered questions. What they need is to cut the red tape and let not just me but some of these families move on – as every family has got other siblings and relatives who are watching a lot of pain and suffering.' [Family of a young woman who died in prison]

5.2.3 b Can the coroner prevent delay?

There is no statutory provision for timetabling inquests or for setting deadlines to reduce inordinate delays. There is also no statutory provision for establishing how far in advance of inquests the (voluntary) disclosure of relevant documentation might occur. The coroner does not have the authority to insist that an investigation is completed within a specific time frame. The current situation means there are no clear lines of responsibility if there are delays. PPO, IPCC or police investigations can hold up coroner's inquests. Conversely, in some cases inquests can proceed before completion of the investigation. Some coroners have adopted a procedure whereby they timetable all inquests but they are not able to compel completion of the PPO/IPCC reports within that timetable as they have no powers to do so.

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20. *Experiencing inquests,* 2002.
21. *How the inquest system fails bereaved people,* 2002, chapter 5.

The four tables below show the deaths in prison and police custody cases that INQUEST has worked on since 2000, the time between the death and the inquest where one has been held and the time between the death and 31 December 2005 where an inquest had not been held.

Table 3: Deaths in police custody – interval between date of death and end of report period 2000-2005 with no inquest held

Date of Death	Interval (wks)	Date of Death	Interval (wks)	Date of Death	Interval (wks)
2000		**2003**		**2004**	
01/08/2000	283	09/01/2003	155	08/01/2004	103
11/10/2000	272	03/05/2003	139	22/05/2004	84
30/10/2000	270	15/07/2003	129	22/09/2004	66
		15/07/2003	129		
2001		07/09/2003	121	**2005**	
23/12/2001	210	21/09/2003	119	14/01/2005	50
28/12/2001	209	27/09/2003	118	28/04/2005	35
		07/10/2003	117	30/04/2005	35
2002		03/11/2003	113	22/07/2005	23
26/04/2002	192	06/11/2003	112	31/07/2005	22
14/08/2002	176	10/12/2003	107	06/08/2005	21
				21/08/2005	19
				21/11/2005	6

Source: INQUEST cases where an inquest had not yet been held between 2000-2005, where the date of death is known

Table 4: Deaths in police custody – interval between date of death and inquest held 2000-2005

Date of Death	Interval (wks)	Date of Death	Interval (wks)	Date of Death	Interval (wks)
1998		**2000**		**2002**	
01/04/1998	121	16/01/2000	106	25/03/2002	30
28/05/1998	86	20/01/2000	33	01/05/2002	63
22/09/1998	81	23/02/2000	64	05/05/2002	62
02/11/1998	220	01/08/2000	276	06/08/2002	170
				30/08/2002	162
1999		**2001**		07/10/2002	136
11/01/1999	243	02/02/2001	42	15/10/2002	111
01/02/1999	59	24/05/2001	114	25/12/2002	31
10/04/1999	68	12/07/2001	177	28/12/2002	127
20/05/1999	146	16/07/2001	173		
13/07/1999	119	25/08/2001	167	**2003**	
06/08/1999	59	03/11/2001	57	02/06/2003	130
22/09/1999	143			06/06/2003	107
16/10/1999	56				
10/11/1999	128			**2004**	
19/12/1999	37			15/05/2004	34
				2005	
				04/05/2005	27

Source: INQUEST cases where an inquest was held between 2000-2005

Table 5: Self-inflicted deaths in prison – interval between date of death and end of report period 2000-2005 with no inquest held

Date of Death	Interval (wks)	Date of Death	Interval (wks)	Date of Death	Interval (wks)
2000		**2004**		**2005**	
08/05/2000	295	18/01/2004	102	10/01/2005	51
		26/01/2004	101	19/01/2005	49
2001		21/02/2004	97	20/01/2005	49
20/09/2001	223	14/03/2004	94	22/01/2005	49
		03/04/2004	91	02/02/2005	47
2002		18/04/2004	89	12/02/2005	46
23/11/2002	162	18/04/2004	89	18/02/2005	45
		21/04/2004	88	05/03/2005	43
2003		08/05/2004	86	09/03/2005	42
01/01/2003	156	08/05/2004	86	24/03/2005	40
14/01/2003	155	11/05/2004	86	19/04/2005	37
13/05/2003	138	24/05/2004	84	03/06/2005	30
24/11/2003	110	01/06/2004	83	12/06/2005	28
26/11/2003	109	11/06/2004	81	15/06/2005	28
28/12/2003	105	03/07/2004	78	26/06/2005	27
		28/07/2004	74	26/06/2005	27
		29/07/2004	74	03/07/2005	26
		07/08/2004	73	04/07/2005	26
		08/08/2004	73	11/07/2005	25
		09/08/2004	73	13/07/2005	24
		25/08/2004	70	01/08/2005	22
		28/08/2004	70	09/08/2005	21
		01/09/2004	69	20/08/2005	19
		28/09/2004	66	21/08/2005	19
		10/10/2004	64	15/09/2005	15
		12/10/2004	64	20/09/2005	15
		15/10/2004	63	28/10/2005	9
		24/10/2004	62	11/11/2005	7
		01/11/2004	61	01/12/2005	4
		17/11/2004	58		
		27/12/2004	53		
		29/12/2004	52		

Source: INQUEST cases where an inquest had not yet been held between 2000-2005, where the date of death is known

Table 6: Self-inflicted deaths in prison – interval between date of death and inquest held 2000-2005

Date of Death	Interval (wks)
1997	
27/11/1997	225
1998	
28/02/1998	123
04/12/1998	64
1999	
04/06/1999	34
17/07/1999	43
21/07/1999	63
03/08/1999	42
01/11/1999	63
08/11/1999	26
11/11/1999	19
11/11/1999	19
14/12/1999	72
2000	
01/02/2000	87
20/03/2000	64
22/03/2000	52
28/03/2000	49
01/04/2000	95
04/04/2000	50
20/04/2000	28
27/04/2000	21
16/06/2000	14
19/07/2000	26
02/08/2000	35
08/09/2000	39
10/09/2000	24
26/09/2000	180
27/09/2000	40
08/10/2000	41
17/10/2000	28
26/11/2000	12

Date of Death	Interval (wks)
2001	
07/02/2001	43
14/02/2001	43
17/02/2001	35
30/03/2001	42
11/04/2001	4
20/04/2001	21
25/05/2001	108
03/06/2001	21
27/07/2001	71
30/07/2001	32
13/08/2001	16
28/09/2001	50
10/10/2001	82
05/11/2001	26
21/11/2001	55
22/12/2001	24
25/12/2001	112
2002	
04/01/2002	82
26/01/2002	175
23/03/2002	55
24/03/2002	108
10/04/2002	98
12/04/2002	42
11/05/2002	177
11/05/2002	87
12/05/2002	104
27/05/2002	132
27/06/2002	24
10/08/2002	61
18/08/2002	97
19/08/2002	105
09/09/2002	126
17/09/2002	33
02/10/2002	50
02/10/2002	122
07/10/2002	112
18/10/2002	106
26/11/2002	102
04/12/2002	25

Date of Death	Interval (wks)
2003	
03/01/2003	110
03/01/2003	110
18/01/2003	103
19/01/2003	81
06/02/2003	38
21/02/2003	121
21/02/2003	83
21/02/2003	101
27/02/2003	39
08/03/2003	44
29/03/2003	82
20/04/2003	93
24/04/2003	134
01/05/2003	82
04/06/2003	90
21/06/2003	127
04/07/2003	28
18/10/2003	69
22/10/2003	90
04/11/2003	85
12/11/2003	107
15/11/2003	67
19/11/2003	36
2004	
04/01/2004	74
13/01/2004	54
13/01/2004	65
04/02/2004	85
07/02/2004	56
24/02/2004	28
04/03/2004	67
28/04/2004	28
15/05/2004	79
07/06/2004	37
10/07/2004	44
03/10/2004	59
10/10/2004	36
09/11/2004	43
2005	
14/02/2005	34

Source: INQUEST cases where an inquest was held between 2000-2005

Questions about delay have been asked in parliament and answers often include the phrase "the information requested is not held centrally". Answers to specific questions have emphasised the rare nature of long delays in the system when in reality it is one of the primary concerns of all involved in the system, not only bereaved families. For example:

"*Miss McIntosh*: To ask the Secretary of State for the Home Department in what circumstances a delay of over three years might occur between a suspicious death and a coroner's inquest.

Paul Goggins: Such a delay would be highly unusual. It may be difficult to obtain all the evidence required by the coroner, particularly if the death occurred abroad. Or the coroner may be awaiting the outcome of criminal proceedings or investigations by other bodies."[22]

In fact the current situation requires urgent action to provide adequate interim resources to investigators and coroners to rectify the problem. An urgent audit of the caseload of each coroner's jurisdiction should be carried out by the Department for Constitutional Affairs as this information is currently unavailable centrally. Consideration should be given to allocating additional resources in the form of full time deputies to jurisdictions with the most prisons and other places of detention. Consideration should also be given to adopting a casework management approach in inquests into deaths in custody with clear timetables set out at the initial opening of the inquest, subject to regular review.

5.3 Access to justice: legal representation and preparation

5.3.1 Legal representation

"Participation of the next-of-kin in the investigation into a death in custody is an essential ingredient of Article 2 compliance. …[I]n all cases of deaths in custody, funding of legal assistance should be provided to the next-of-kin.'" (Parliamentary JCHR)[23]

5.3.1 a Changing attitudes: the approach to legal representation

As the only official public hearing where the facts can be established about a death in detention which has not merited criminal prosecution, the inquest is of crucial importance in the quest for the truth. Inquests have been a forum for the struggle between bereaved families and those in authority to establish how someone died and whose 'truth' is finally put on public record.

Traditionally viewed as less formal hearings than many, legal representation for bereaved families at inquests was not considered necessary. Subsequently families who obtained free legal representation were accused of using inquests as 'fishing expeditions' in order to pursue further legal action for compensation and made to

22. *House of Commons Hansard*, Written Answers for 21 Feb 2005, column 445W.
23. *Deaths in Custody: Third Report of Session 2004-05 Vol I* 2004, para 309, p88.

feel that their representatives were interfering in the coroner's inquest. Some coroners were openly hostile to legal representatives for bereaved families, regarding their contribution as a hindrance rather than helpful to the conduct of the inquest.

The reality for most families is that there is no possibility of further legal action. In a majority of cases there is no recourse to the civil court because the deceased is over 18 and has no dependants. It is now possible to pursue civil claims under the HRA 1998 articles 2, 3 and 8 but only in a minority of cases. The inquest is therefore the only opportunity for the family to find out what occurred.

By seeking legal representation to assist them through this long, complex and daunting process they hope to prevent future deaths; in contributing to that objective some meaning and purpose can be given to their loss. Attitudes have changed and some coroners actively encourage and welcome participation by family legal representatives. Others have supported family applications for funding for representation because they recognise the useful role the lawyers can play in ensuring the inquest meets the standards required by recent judgments and case law.

*"Members of the INQUEST Lawyers Group have been involved for many years in actively advancing the civil liberties of the friends and families of the deceased. Invariably these lawyers came from professional backgrounds that included expertise in civil actions against the police and criminal defence. The range of legal experience that they brought to an inquest made the proceedings quite different to an inquest where a family was not represented. There are some coroners who feel threatened by the mere presence of a lawyer representing a family… It should, however, be emphasised that other coroners positively embrace the assistance and engagement of legal representatives." (*Thomas *et al)*[24]

In pushing at the boundaries of the inquest system lawyers instructed by families have helped to expose systemic and practice problems that have contributed to deaths. Many of the changes to police and prison officer training and guidance, changes to the law in relation to inquests, increases in information entering the public domain about deaths in custody, and increased public awareness of the issues have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying work thereafter for change.

In the absence of legal representation on behalf of the family, it is unusual for a coroner to conduct the kind of searching questioning that occurs when they are represented. There are custodial deaths that have not been properly scrutinised because families did not have information and the resources to be legally represented, where the deceased had no family interested in participating in the inquest or no family at all.

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24. *Inquests: a practitioner's guide*, 2002, para 12.17, p140.

"While it is true that the adversarial interests of parties appearing before the coroner can sit oddly with the coroner's inquisitorial role, this does not mean that the adversarial forms are always in conflict with the coroner's quest to uncover what happened; rather the competent advocate can help the coroner by highlighting shortcomings in the evidence and forcing a reassessment of the evidence." (The Inquest Handbook)[25]

In contrast, the detaining authorities have traditionally approached the inquest as a damage limitation exercise, attempting to close down questioning and narrowing its remit. Lawyers representing custodial institutions are often instructed to take a defensive approach to the proceedings, trying to shroud what happened in secrecy or to attack the character of the deceased rather than assisting the court in the exercise of an impartial scrutiny of the death. The most extreme examples of this have occurred in highly contentious cases where a number of interested persons, other than the family, have clearly been seen to be acting as a team against the family and the deceased.

5.3.1 b Inequality of resources

At all inquests into deaths in custody the institutions of detention will be legally represented[26] by experienced and well-qualified lawyers at unlimited public expense. As Tom Luce pointed out, "if a police authority or a health authority is involved in an inquest, its legal costs will be met by its budget, which is a publicly tax-financed budget".[27]

Families have no access to non means tested public funding and often cannot afford legal representation. Those without legal representation have found themselves alone facing barristers from detaining institutions and sometimes lawyers representing individual officers or others[28] funded through union or professional association resources.

'I do think that deaths where state agencies have played a part should be state-funded, regardless of the means of the family. There's an article 2 obligation for deaths to be properly investigated so we should not be considering who might own what, or own their own house. The family haven't asked for this death to have occurred, it's not something that they are willingly embracing or deciding to gamble to get compensation for their own broken leg or something … it's descended upon them in the most horrendous way and I think it should be properly funded.' [Solicitor, Leeds]

"Inquests into deaths in custody normally last at least a week but have been known to last as long as three to eight weeks. Experienced counsel invariably represent public authorities, whose conduct might be open to criticism at such inquests. Despite all these factors, which

25. *The Inquest Handbook*, 1998, p xxii.
26. See reference to PSO 2710 below.
27. *Reform of the coroners' system and death certification Eighth Report of Session 2005–06 Volume II,* 2006, Ev20.
28. Nurses, doctors, social workers, etc.

militate against the concerns of a family being properly audited in a public forum, the guarantee of public funding continues to remain elusive." (Thomas *et al*)[29]

HM Prison Service Order 2710 'Follow up to deaths in custody', implemented in January 2006, recommends legal representation for prison staff at all inquests. In most cases the Prison Service will also be legally represented. The police take a similar approach and in most inquests into a death in police custody the Chief Constable or Metropolitan Commissioner will be represented as will individual police officers.

Until the Access to Justice Act 1999 heralded the beginning of the process that made some public funding available, legal work was done on behalf of bereaved families for free. As we have discussed in chapter 2, members of the INQUEST Lawyers Group have been at the forefront of developing legal practice in relation to representing families at inquests with a particular focus on deaths in detention.

> 'Without the help of INQUEST we could not have been represented at the inquest. We could not get legal aid for this. But the Prison Service could. We feel this is totally unfair.' [Family of a young man who died in a young offender institution]

We have discussed in earlier chapters the importance of early access to legal advice from the point of the first post mortem examination and through the entire investigation, which all forms part of the preparation for the inquest hearing. After the investigation is complete the coroner begins the process of organising the full hearing. It is crucial at this stage that the family is legally represented.

5.3.1 c Funding legal representation

Bereaved families face considerable problems in obtaining the limited means tested public funding that is now available for legal preparation and representation, despite the fact that they are involved in a complex legal process through no choice of their own.

'Why should people fork out money to be represented at the state's investigation; it's totally unjustified.' [Solicitor, Leeds]

'It's not like litigation where you can think 'Well, OK, in that case I'm not going to go ahead'. Things are going to happen regardless, you're going to be there regardless, you're going be involved regardless.' [Solicitor, London]

'The lack of clarity regarding the funding situation is very difficult. Families ask us and we can't answer them clearly. The family then gets very worried about the legal bill.' [INQUEST caseworkers]

> '[We got funding] but there was a problem regarding the number of hours.' [Family of a young woman who died in prison]

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29. *Inquests: a practitioners guide*, 2002, para 11.1, p120.

> 'We had bad problems. The LSC agreed to exceptional funding two days before papers for judicial review were to be filed yet we had given them no extra information. They have still not agreed to enough funding to cover the preparation.' [Family of a young woman who died in prison]
>
> 'I was not eligible for legal aid and was initially quoted costs of a minimum of £5000. Fortunately it has been possible to reach an agreed cost I can afford without getting into a large debt.' This respondent's husband died in prison. She works part-time earning less than £15,000 a year. [Family of a man who died in prison]
>
> 'I got legal aid but had to pay for the barrister myself.' [Family of a man who died in prison]

INQUEST Lawyers Group members are consequently involved in lengthy and time consuming work to obtain funding, facing little uniformity of approach from decision makers in the Legal Services Commission (LSC). This detracts from the work that needs to be done to prepare for the inquest. Much work is still undertaken for free. Many solicitors say that conducting an inquest case costs their firm more than the fees the LSC allocate to the case.

''We are subsidising the public purse.' [Solicitor, London]

'[The LSC] are unreasonable in the amount of work that they'll pay for and the rates you can charge. They expect solicitors to do very little work indeed under exceptional funding.' [Solicitor, London]

'I don't think anyone makes a profit out of this – far from it.' [Solicitor, Leeds]

Even where the decision to fund is positive it is often only partial and requires a contribution from families. Practitioners have described the position as 'invidious' and some solicitors subsidise cases rather than asking for financial contributions from families they know cannot afford to pay. Families' access to public funding is conditional, subject to tests and always requiring justification.

'With the LSC and the DCA the presumption is to refuse to fund unless solicitors prove otherwise.' [Solicitor, London]

The LSC approach exacerbates the distress of families who find themselves involuntarily enmeshed in a legal process. The questions asked are often intensely personal, embarrassing and experienced as highly intrusive. Sometimes families have decided not to participate in the inquest because this process is too distressing and causes too many problems within the family group. Before making their decision, the LSC has asked for extensive information about the means of family members who were either not interested in the inquest, were not on good terms with the person applying for legal help and/or the deceased, or did not live in England or Wales. This presupposes that all members of a family are united in their approach to the death,

when the reality is often more complex and a solicitor may only be instructed by one member or wing of a family.

'That you have to explore the financial resources of everyone is absolutely hopeless, particularly because after a death there may be different factions within the family. It is not right that you have to find some dreadful common denominator and represent people who won't speak to each other.' [Solicitor, Leeds]

'The main problem with LSC funding is the requirement to provide information about other family members' means…where do you draw the line, how close a family member does it have to be? This can cause difficulties between spouses or common-law spouses of the deceased and biological family…there are many situations where funding is refused on the basis of other people's means when those other people aren't prepared to pay or aren't interested.' [Solicitor, London]

'I had one case where the deceased was from Ghana and the LSC wanted to know the earnings of the relatives who lived in Africa – obviously this was very difficult and consequently the decision took a very long time. It is this kind of delay that discourages the family from taking part in the process.' [INQUEST caseworkers]

'The whole issue in relation to contribution is terrible. The requests by the LSC to provide detailed financial information of family members who often cannot even be contacted is ridiculous.' [Solicitor, London]

'Ideally, the means would be only those of your client, and people who you're not instructed by would be out of the picture … On the whole, if some family members qualify financially then most of the family are not that well-off… Maybe the solution would be to have different eligibility levels for inquests on the basis that it will go ahead regardless and is something that families didn't choose.' [Solicitor, London]

'When you have someone on a modest or medium income…it's just abominable to think of anybody paying privately for an investigation into the death of their nearest and dearest.' [Solicitor, Leeds]

There is clearly little in depth understanding at the LSC about the context and impact of their decision making process.

'In another case, the LSC wanted the family to instruct a solicitor who was located geographically nearest to them – but this solicitor had no experience of conducting a death in detention inquest case – another example of the failure to understand the specialism required for a family to have effective representation.' [INQUEST caseworkers]

'The LSC see it as a non-specialised area of law and they'll say you don't need to use counsel in London, you should use someone in your area, which I can't do.' [Solicitor, Burnley]

The need for specialist lawyers in these cases is not understood by the LSC. Funding for London based lawyers to attend inquests outside

London is often refused. Suggesting families should use local lawyers underlines the lack of equality in the approach to legal representation. In most of the controversial deaths in custody cases the Prison Service/police will go to Treasury Counsel in London or specialist police chambers, all based in London.

This lack of understanding extends to a failure to understand the impact of the introduction of the new investigation processes, protocols on disclosure and the changes to the inquest process following the *Middle*ton and *Amin* judgments. The amount of disclosed information and the subsequent time spent analysing it and intervening at this stage has increased significantly. Inquests into deaths in custody are now taking much longer and can last more than six weeks in complex cases.

'I was recently doing a case where I realised that counsel for each of the four police interested persons were being paid at least eight times more than the LSC rates. The case had 13 lever arch files and lasted six weeks. It was upsetting, because I had done the case out of a sense of duty because I thought the client really needed experienced counsel. I have been doing inquests for years, and recently with some limited funding from the Special Cases Unit at the LSC. Those of us who represent families at inquests feel it would be wrong to seek to criticise the rates of pay. However, in a sense this is second class justice for the deceased's families. Why should the state choose to pay the families' lawyers a second rate level of pay, whereas other arms of the state pay for the best teams of lawyers usually including Treasury Counsel and solicitors at proper rates of pay.' [Barrister, London]

Family representatives are frequently a lone voice amongst the other parties who usually share a broadly similar view on the case. They are also often the most experienced in terms of the application of recent case law, guiding the coroner and others on relevant points.

'Lawyers representing the family often do so in isolation, in terms of the issues they seek to push to be explored at the inquest. More often they have a single voice, whereas those representing other interested persons sing in unison together like a team effort. I do not think it is an understatement to say in terms of the work put into the inquest, it is certainly equal to, if not exceeding, that of the other interested persons.' [Barrister, London]

'The complexity of preparation should be recognised by an improvement in the rates and its inclusion in the exceptional funding. In that way families will receive better pre-inquest preparation.' [Solicitor, London]

'The investigation made over 400 recommendations in two lever arch files yet the LSC is likely to grant only two hours to brief counsel!' [Solicitor, London]

Delay in the decision making process about funding is also common and places unnecessary burdens on the family and their lawyers. This

process has been described by practitioners as involving a game of brinkmanship. There are cases where funding was refused up until the full inquest hearing and occasionally after the inquest, and then eventually paid even though no new information about the means of the family members involved was provided. This again creates unacceptable levels of anxiety for bereaved families. For some the stress is too much and they decide not to have legal representation.

'I've had cases where counsel and myself have gone to the inquest without funding, we have had a real battle with the LSC who granted funding about a month after the inquest. Not all counsel are prepared to do this and therefore families are put in a very vulnerable position.' [Solicitor, London]

'In another of my cases, by the date of the inquest there had been no decision on funding and on the day the family had to decide whether to instruct counsel and pay them, in the hope that the LSC would reimburse them. In the end they decided they simply couldn't afford it and we had to find a barrister to act pro bono.' [INQUEST caseworkers]

We think that current practice contradicts article 2 of the Human Rights Act 1998 (HRA), which calls for effective family participation. A family cannot participate without professional help but if they cannot afford either financially or emotionally to access that help they will be left to deal with the inquest alone, or disengage from the process completely. If they are lucky they will be able to rely on free representation. All of these options are unsatisfactory and none meet article 2 requirements: the investigation and inquest are only compliant with the HRA if there is effective family participation. There should be reform to ensure an automatic right to non means tested public funding for bereaved families' legal preparation and representation.

In the short term decision makers at the LSC should be trained by relevant organisations to understand the context and impact of a death in custody on a bereaved family. They should be required to shadow a solicitor who represents bereaved families as part of their training to gain better understanding of the nature of an inquest case and the type, quantity, quality and depth of the work involved.

5.3.1 d Quality of legal representation

The introduction of limited public funding has not been accompanied by a concurrent introduction of appropriate quality standards for those representing bereaved people. If families are not signposted to appropriate legal advice they may instruct lawyers with little or no experience of inquests or of deaths in detention. Inexperienced lawyers have represented families and have sat through inquest hearings making no verbal intervention. Some charge huge amounts of money to merely take a note at the inquest.

Standard legal training does not include how to represent families

at inquests and such knowledge within the wider profession is limited. Many solicitors agree to represent families without the understanding that they need to do it effectively.

> 'INQUEST got me a solicitor who had experience of deaths in custody. I now know any local solicitor in my area would have been hopeless to my son and his family. Being told that I could still deal with a London solicitor by phone, fax or post would not hinder my son's case in any way, which it hasn't.' [Family of a man who died in prison]

Currently the only panel of lawyers with specific expertise in representing people bereaved by deaths in custody is the INQUEST Lawyers Group. The Law Society should explore better ways of ensuring the quality of legal work provided with the INQUEST Lawyers Group. They should discuss how quality standards in this area could be included in the current quality assurance and franchising mechanisms.

5.3.2 Legal preparation

Coroners have very wide discretion in the running of their court. If a bereaved family wants to make suggestions to the coroner, for example about witnesses, issues they think should be addressed or disclosure of documents, there is no clear mandatory procedure about how to do this or how to challenge any decision made. The family has no right to call their own witnesses at the inquest: they can bring them to the attention of the coroner who then has discretion as to whether they should be called.

On completion of the investigation the evidence is passed to the coroner who begins to organise the inquest. The family should also have the evidence disclosed to them to enable them to begin their preparation for the inquest. They will need to consider legal representation at this point if they have not already instructed a solicitor. The family will consider the evidence with their lawyer and prepare to discuss suggestions for witnesses with the coroner, as well as instructing a barrister to represent them at the full inquest hearing.

Good quality, experienced legal representation can significantly impact on the quality and outcome of the inquest particularly if the lawyer for the family develops a positive and constructive working relationship with the coroner. This not only helps the conduct of the inquest but also assists the family to feel that they too have some control over the process which is focussed on the death of their relative.

Inquests have had to be adjourned because the official investigation depended on by the coroner failed to question a relevant witness or make the coroner aware of their existence. This is of particular concern in a death in prison where prisoners have complained that they were not interviewed as part of the official investigation but have something relevant to say; the family lawyer has had to make the coroner aware of the potential witness and request that they be called to give evidence.

Judicial review or the threat of it is the only avenue open to a family to challenge a coroner's decisions. Dialogue from the outset with bereaved people and their lawyers, and mandatory pre-inquest hearings (see 5.3.2b), would lessen potential conflict, make families feel they are part of the process and reduce the need for recourse to judicial review which is prohibitively expensive and increases delay.

5.3.2 a Disclosure

"Undoubtedly, the single most difficult aspect of an inquest for the clients will be the coroner's broad discretion to deny any disclosure of witness statements or material prior to the hearing." (Thomas *et al*)[30]

As discussed in chapter 4 there is no mandatory right to pre inquest disclosure of documentary evidence. The IPCC and PPO have considered further the voluntary protocols introduced in 1999 but it remains the case that there is no right to advance disclosure and the issue remains problematic. The experience of INQUEST Lawyers Group members is that when it occurs and how thorough it is depends on an individual lawyer's tenacity. In controversial cases disclosure has been difficult to obtain and its provision has not allowed sufficient time for adequate preparation.

In arguing for disclosure in deaths in custody cases during the 1990s we proposed that it would assist all parties and remove some conflict from the hearing itself; and since 1999 this has been the case where it has operated well. It also reduces unnecessary pain for bereaved people in that they do not have to hear information about how someone died for the first time in public. In all inquests there should be full mandatory disclosure of all information irrespective of whether the coroner intends to call the witnesses, and clear rules about when and how it will be made.

We remain concerned about the pace at which documents are disclosed, the lateness of disclosure and the withholding of critical documents until the day of the hearing. Documents should be disclosed to the family as soon as they become available.

'I had an inquest where a statement from a prison governor was disclosed on the day of the inquest, despite the fact that all the reports had been disclosed beforehand. This statement was critical, [but] we did not even know it existed! The inquest was adjourned as the coroner decided to carry out further enquiries This also impacts on future further costs I now have to argue out with the LSC.' [Solicitor, London]

5.3.2 b Pre-inquest hearings

Pre-inquest hearings have increasingly become the norm in custodial and other complex cases. Some coroners convene a pre-inquest hearing as soon as possible after the conclusion of the initial investigation, whether undertaken by the police, IPCC, or PPO, and following disclosure of the results of that investigation to the interested parties.

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30. *Op cit*, 2002, para 12.13, p138.

A key objective of pre-inquest hearings is to achieve the agreement of the interested persons on the oral and documentary evidence that will be heard during the full hearing. In advance of the pre-inquest hearing, the coroner will usually provide a list of witnesses outlining who he or she intends to call in person and which statements it is proposed to read into evidence at the full inquest. The hearing affords an opportunity for everyone to make submissions about further evidence, and to satisfy the need to ensure evidence is available from individuals of sufficient seniority within institutions to assist the hearing with regard to issues such as training, policy and procedure. It also provides an early opportunity for the coroner and interested parties to agree in principle the likely issues and themes that will be explored at the inquest.

'In prison death cases, for example, seeing whether a site visit might be appropriate.' [Solicitor, Leeds]

Practitioners also use pre-inquest hearings as an opportunity to verse the coroner on the law, which could save adjournments at the full hearing. Any difficulties about disclosure of evidence can be resolved. Discussion and agreement can happen about suitable expert witnesses and the form and method of their instructions. In complex and difficult cases, the preparation of bundles for the use of the court, witnesses and interested persons can be organised. It is not uncommon for more than one pre-inquest hearing to prove necessary in complex cases. It is also at the pre-inquest hearing that the date for the inquest can be set in a manner that takes into consideration all the different concerns.

Some lawyers take the family to the pre-inquest hearing, which allows them to meet the coroner, for the coroner to speak to them and express any condolences in a more informal setting. This helps the family to feel part of the preparation process and also allows them to be shown the Coroners Court and facilities. They are more likely to be encouraged to give evidence if they feel part of the process.

5.4 The inquest itself: the hearing and its outcomes

5.4.1 Conduct of the inquest hearing

During the inquest hearing the coroner conducts the inquiry assisted by those representing different properly interested persons. The coroner will begin questioning the witnesses and there is then the opportunity for barristers representing any interested person to question them. The family member will be one of the first witnesses called. This can sometimes be a very negative experience but as we show below for some it has been an important opportunity to express how they feel about the death of their relative and the impact it has had on them.

For many families the inquest is the public culmination of a process that is overwhelmingly intrusive. Their finances and those of their extended family may have been inquired into so as to assess their

eligibility for public funding and in many cases their life history has become part of the investigation. Evidence is heard in public and families may be questioned about intensely private aspects of their lives. In this sense for them to engage with the process is a courageous and generous act.

It can be frustrating for the family if the coroner decides to take an unnecessarily restrictive view on his/her role in simply establishing the facts surrounding the death and disallows questions on the basis that they are not relevant.

> 'After it had taken our lives over for so long it was a huge anti-climax, especially because of the outcome. I felt that it hadn't really answered anything.' [Family of a man who died following contact with police]

Families can be left with a perception that the coroner is not impartial but on the side of the authorities.

> 'We feel you cannot win against a government institution.' [Family of a young man who died in prison]

5.4.1 a Insensitive treatment of families

Families have complained frequently to us about, or we have witnessed, insensitive and sometimes prejudiced behaviour by coroners, witnesses and other representatives. The whole process is unfamiliar and frightening to most lay people. We have observed institutionalised behaviour where little thought has been given to the impact on the bereaved: for example, post mortem photographs being waved about; or a gun being trained around the court by the coroner and pointed inadvertently at the family of a man shot dead by the police.

The questioning of the family witness by other parties can often be insensitive to their bereavement and their inexperience of the procedure; sometimes it can be rude. Other parties have been perceived by families as seeking to destroy the humanity of their relative and blame them for their own death.

> 'We should have been allowed to give an overall view of the deceased, I feel it would have helped the jury. They had a one-sided view of him.' [Family of a man who died in prison]

> 'The whole system requires a full overhaul. The families should be treated with respect, we were made to feel that we had committed crimes ourselves.' [Family of a man shot dead by police]

Others have been thoughtful and considerate – for example warning families that post mortem evidence and photographs are about to be examined and they can leave the court if they wish. It is deeply shocking to see photographs of someone who is dead, particularly post mortem photographs of a relative or friend. That some professionals involved in inquests fail to manifest basic empathetic responses is indicative of the alienation present in those

services and a consequence of the lack of proper training and support. Those working in the coroner service and detaining authorities need to make a conscious effort as part of their professional approach to not treat the family and the rest of the court as if they were hardened experts.

Families' frequent perception of the inquest is that coroners close ranks with other professionals and that there is institutional bias from coroners in favour of the authorities. This may be inevitable but can be mitigated if the family has been able to attend the pre-inquest hearing and meet some of the professionals concerned in a less stressful setting.

Respect and basic humanity shown to the family by those in authority can have a positive impact on their perception of the whole hearing. For example, asking the family if they would like the person who has died to be referred to during the hearing by first or last name. It can also assist if the coroner agrees to show the jury photographs of the family member in happier times, which humanises them in the minds of jury members. In many cases there can be negative perceptions reinforced throughout the inquest by the manner in which the coroner questions witnesses and allows or disallows questions from the family lawyer. In some inquests coroners have been unwilling to allow the family's concerns to be fully explored or their questions to be asked.

> 'We felt he conferred with the police and doctors legal team before making his mind up [if the question could be asked].' [Family of a man who died following contact with police]

> 'He was willing for [questions] to be asked, but not for them to be answered.' [Family of a young man who died following police pursuit]

> 'No questions were allowed. The coroner wouldn't let our son speak.' [Family of a man who died in prison]

This contrasts sharply with others who have had a more positive experience:

> '[He was] very willing indeed [for questions to be asked]. He was a lovely caring man. Asked a lot of questions himself and was very thorough.' [Family of a man who died in prison]

> 'Very willing [and there were] no restrictions.' [Family of a young woman who died in prison]

5.4.1 b Legal submissions on possible verdicts

After all the witnesses have been questioned, barristers may request, or the coroner might invite, written and/or oral submissions to be made on the law in relation to possible verdicts. The jury is asked to leave the court until the legal submissions have been made. These submissions, including a summary of the relevant law, can help the coroner achieve a more balanced and comprehensive summing up.

It is also an opportunity to encourage the coroner to give reasons for his/her decision. However as one experienced lawyer observed:

'The artificial insistence that one cannot touch on the facts, even by way of example, can make that submissions somewhat vacuous' [Solicitor, Leeds]

5.4.1 c Summing up of the evidence for juries

Once the legal submissions have been completed and considered, the coroner brings the jury back into court, sums up the evidence and directs the jury on the verdicts they can consider. From a family perspective this point in the hearing is crucial and has a lasting impact on the family's experience of the whole process. How coroners approach summing up can be influenced by legal submissions made by counsel for the family and other persons.

Since the *Middleton* judgment how this part of the hearing is approached has important consequences for the outcome (see below).

Coroners have made inaccurate summaries of the law, or have taken a view on the case from the outset which was not supported by the evidence and appeared to direct the jury away from a critical verdict. Some coroners do not announce at the beginning of their summing up what verdicts they intend to allow the jury to consider and the family has to wait until the end of a long review of the evidence. Given the unfamiliarity of most bereaved families with the inquisitorial system, if the coroner's summing up seems biased, the family then wonder why their barrister cannot also make a closing speech.

A minority of families felt positive about the summing up, believing it was accurate, fair and easy to follow. A majority felt it to be inaccurate, that it omitted important facts, that it was unfair, biased and confusing. In many of the inquests that have been challenged in the High Court it is the coroner's summing up of the evidence and subsequent legal directions to the jury that have been central to the case. This underlines how important it is that coroners who hear these kinds of cases should be experienced and well versed in relevant law.

5.4.1 d Role of the jury and impact of narrative verdicts

The importance of the jury in these cases cannot be overestimated, particularly where families feel the whole process is stacked against them from the outset. Faced with the contradictions and narrow remit of the inquest system, families often doubt the independence and impartiality of the coroner. Suspicion of the process is heightened for families from black and minority ethnic communities and a representative jury is crucial. Families know that the jury is not part of the establishment and that if its members truly reflect the community their peers are scrutinising the circumstances of the death.

Lord Justice Auld's recommendation in the Criminal Courts Review "that a scheme should be devised, … for cases in which the court considers that race is likely to be relevant to an issue of importance in

the case, for the selection or a jury consisting of, say, up to three people from any ethnic minority group"[31] was not implemented. However, we think consideration should be given to this issue in a reformed inquest system.

'There is no jury selection process. In one case of mine this was noticeably problematic with a black death investigated by an all white jury.' [INQUEST caseworker]

The inquest provides a forum whereby the official version of events can be challenged – the jury adds an element of independence, which is particularly important in cases where questions of unreasonable force or gross negligence arise. Moreover, the pace and tone of the proceedings are tamed by the presence of the jury: evidence must be presented in a manner that is accessible to them, and hence also to the family and the public.

There should be an agreed mechanism to ensure that the jury is made up of peers of the deceased and that there is a mechanism to ensure different interested persons can make representations on jury selection.

The active participation of the jury in the inquest is dependent on a number of factors: how the coroner explains their role, so they understand that they can ask questions and have an active role to play; the hours the court sits (which must be reasonable); and the facilities the jury have available to them such as pens, paper etc.

> 'The importance of the role of the jury should be highlighted to them, they are not there just to fill seats.' [Family of a young woman who died following release from police custody]

> 'At first, two [members of the jury] didn't take it seriously but at the end they were in tears.' [Family of a man who died in prison]

> 'Overwhelming for the jury at first but [I] could see that they started to pick up the story and see the many issues as the day went by. They needed an outline of the issues at the beginning so that they knew what it was all about.' [Family of a man who died in police custody]

> '[They] didn't seem to take all the witness statements into account and were rushed to reach their verdict.' [Family of a young man who died following police pursuit]

Where the coroner has ensured the jury understand their role it can add to the meaningful conduct of the inquest for the family.

> '[They were] extremely fair. Their reaction at the end of the inquest showed them to be very sympathetic.' [Family of a man who died in prison]

> '[The jury were] very attentive and concentrated on all of the evidence. They asked many questions.' [Family of a man who died in prison]

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31. *Review of the Criminal Courts in England and Wales,* 2001, ch5, para 62, p159.

> 'Their role was very, very important. [They were] able to ask more direct questions and get the answers.' [Family of a man who died in prison]

> 'They took a serious interest and appeared concerned at events at the prison.' [Family of a woman who died in prison]

The verdict is an important, although sometimes unsatisfactory, outcome at many inquests. Our practice and that of INQUEST Lawyers Group members has been to work with families to focus on the totality of the evidence but the content of the verdict will always be very significant. If the verdict does not reflect the evidence heard at the end of a gruelling and distressing experience, the inquest can be disappointing for families. Even the option to return narrative verdicts (see below) does not always result in a fair reflection of the evidence heard. This is to be expected as juries reflect the views of wider society. It also underlines the importance of the role of the coroner in ensuring the inquest has a meaningful outcome, in particular to use his or her powers to report matters of concern under r43.

Traditionally the power of juries to frame verdicts has been seriously circumscribed and they have been prohibited from making any independent recommendations. Prior to mid-2004 the practice had developed of relying upon short form verdicts, for example; killed himself/herself whilst the balance of his/her mind was disturbed/suicide; accident/misadventure; natural causes; open verdict.

The consequence was that even where the inquest adopted an expansive role, including full consideration of systemic failings, the coroner or jury was inhibited from reflecting in the verdict anything more detailed than that the death was contributed to by neglect.

> 'I was not happy with the verdict, after all the facts came out, how they came to accidental death was beyond us as the neglect was there to see. It seemed like the solicitor for the Home Office was trying to stop facts coming out.' [Family of a man who died in prison]

> 'The jury were out for five and a half hours deliberating their verdict as they were not unanimous in their decision. The coroner had to tell them that he wanted a verdict by that night as he did not want to carry on to the following day.' [Family of a young man who died following police pursuit]

> 'The coroner's hearing was extremely well planned in so far as it suited the purpose of the state to leave out the witnesses and evidence that would have painted a clear picture of how my daughter came by her death – i.e. an absolute whitewash. My views didn't count. As this was the case, the jury were in effect backed into a corner of bringing no other verdict. They hadn't a clue about the case.' [Family of a young woman who died following release from police custody]

> 'We all felt that it was an unfair verdict. If the jury had taken into account the police's role in the accident, then a fairer verdict would have been reached.' [Family of a young woman who died in prison]

The changes brought about by the *Middleton* judgment have had their most visible impact in the options now available to coroners at the conclusion of inquests into deaths in custody. These changes occurred during the writing of this report. Coroners are now able to leave the option of a narrative verdict to the jury which can be more meaningful both for state agencies responsible for implementing changes in policy and for bereaved families. But how the verdicts are formed is dependent even more on coroners being fully trained and aware of the law, and on families being legally represented by competent lawyers.

Fuller analysis of the impact of narrative verdicts will be available elsewhere[32] but so far the impact on bereaved families is broadly positive. Narrative verdicts can reflect a range of conclusions that identify systemic contributions to the cause of death and the identification of changes to be implemented in a range of factual scenarios. They have the potential to make a significant contribution to the prevention of future similar fatalities. However, not every jury in a death in custody case will be directed to consider a narrative verdict and they may still be offered only a selection of short form verdicts. Further, as coroners explore how best to extract a meaningful narrative from a jury it is becoming apparent that different approaches are suited to different circumstances and some coroners are better at engaging a jury in the task than others.

'My experience is that families have been very satisfied with narratives, since they provide scope for the jury to apply their minds to the issues.' [Solicitor, Leeds]

'Narratives are sometimes better because neglect is so hard to get, and families who want to establish it often don't and that is quite upsetting for them. I think it's more helpful to get away from a 'win or lose' approach, and not get too hung-up on neglect.' [INQUEST Caseworker]

5.4.1 e Coroner's Reports under Coroners Rules 1984 rule 43

One of the most important powers a coroner has is to announce[33] that he or she intends to report the circumstances of death to those authorities who have the power to take action to prevent the recurrence of such fatalities. This power is the coroner's alone.

One of the ways in which families seek meaning from their experience is in the hope that some good or learning will come from the death of their loved one. Despite all the difficulties families have

32. *Narrative verdicts – an analysis of the impact of the Middleton judgment*, forthcoming.
33. Coroners Rules r43. Sometimes r43 reports are mistakenly referred to as coroners' recommendations.

encountered, their expectations are high about what the inquest can achieve. Although many find their experience of the hearing has narrowed those hopes, if the coroner openly acts under r43 it can help the family, improve the institutions of detention and enable wider society to learn from the death. A number of coroners value the important role they have in the prevention of future fatalities and make regular use of their power under r43.[34]

There is however a problem regarding coroners' interpretation of r43. Some will not make reports on matters that have been addressed by the investigation while others will report on matters of concern relating to the death irrespective of whether it was directly linked to the person's death. There is variable practice in relation to coroners announcing their intentions in open court.

5.4.2 After the inquest hearing

Where a family has had the ability to participate effectively in the inquest, have had answers to some of their questions, and seen a verdict and rule 43 reports reflect the evidence, an important turning point in dealing with the aftermath of the death is achieved. In chapter 6 we discuss the emotional impact of the experience but here highlight problems encountered by families after the hearing.

In the period covered by this report over two thirds of families we asked were dissatisfied with the conduct of the inquest. This ranged from complaints about the way they were treated throughout to dissatisfaction with the verdict. Others felt that with the completion of the inquest they lacked any formal mechanism to find out if anything had changed in relation to failings identified and what action would be taken to ensure that jury findings or coroner's reports were acted upon and implemented.

5.4.2 a. Challenging the verdict or poor hearing

If the family is unhappy about the way the inquest has been conducted there is no right of appeal or easily accessible and effective complaints procedure.

The only way to challenge the outcome of the inquest or the way it has been conducted is by judicial review, which is a lengthy, expensive and difficult process. A successful outcome can be that the original inquest verdict is changed and replaced by the high court or that a new inquest is ordered. The exercise of this power depends on the court's view that it would be necessary, desirable and in the interests of justice.

However, this subjects families to additional delay in concluding the inquest process. Additionally, if individual police or prison officers or the institutions involved disagree with the verdict they too can opt for judicial review without regard to funding issues. Whilst the process has contributed to positive developments in inquest law, it can also be highly damaging emotionally for all involved.

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34. See *Inquest Law* issues 1 – 10.

> '[We felt] empty. We felt that there should be more to do – more questions to be clarified etc., but decisions had already been made. We were advised that we could appeal by judicial review but were aware of the lengthy process – it had taken two years to get to this.' [Family of a man who died in prison]

5.4.2 b. Failure to monitor and follow up inquest findings and verdicts

"Despite the best endeavours of public spirited coroners and other inquiries there is abundant evidence that their recommendations have often vanished into the ether, thus denying both their inquest and the deaths into which they inquired any useful meaning." (The Inquest Handbook)[35]

The current system is unable to systematically identify failings and ensure corrective action is taken. The findings and reports of coroners and juries following inquests into deaths in custody are not published and therefore cannot be analysed, monitored or followed up.

There is no mandatory procedure to follow once the coroner has used powers under rule 43 or to react to the detailed findings in narrative verdicts. If agencies choose to ignore reports then they may do so with impunity and without scrutiny.

There is no central collation of reports or monitoring of responses. This can have the effect, coupled with the delays in the system, of a disincentive to coroners to use their important powers to take action to prevent similar fatalities.

'There is no central registry of recommendations … you sometimes wonder what happens to them, do people respond or do they go straight into the waste paper basket? In one case I've done the inquest happened last year but we are still waiting for a response.' [Solicitor, Leeds]

'If the coroner does make recommendations, at least if somebody else in twelve months or two years time has another similar case, you could go back and say 'well hang on, these recommendations were made, did you do anything about it?' But if they're not being made, you don't even know that. Some sort of database of recommendations would be helpful.' [Solicitor, Burnley]

'It's whether you see complaints and lessons as a positive thing or a negative thing. And I think that it is too often seen as a negative criticism as opposed to constructive reminders of how there is a real problem with regards to suicide in custody.' [Solicitor, London]

'When recommendations are made, I'm not satisfied that there's sufficient scrutiny as to whether they're adopted, and if not, why not. I think there's scope for the idea that there is potential for judicially reviewing the Home Office's failure to adopt a rule 43 recommendation. If a coroner is concerned enough to make a potentially life-saving recommendation, there is no reason why acceptance of that shouldn't be subject to public scrutiny.' [Barrister, Manchester]

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35. *The Inquest Handbook*, 1998, p xviii.

Some coroners will provide the family and their representatives with copies of any response they receive from the relevant authorities but there is no obligation for them to do so. Coroners are also treated with a lack of respect by the detaining authorities – we have examples of coroners still waiting over a year for a reply about their concerns or who have received no response whatsoever. The lack of monitoring of reports and responses detracts from the standing coroners should have as judicial officers and the important practical and policy impact inquests could have in preventing future fatalities and near death incidents.

The relationship between the inquest and the investigations carried out by the PPO and IPCC is also in need of review in relation to CR r43 as discussed in chapter 4.

A reformed system must produce a systematic way of learning from the deaths. Currently findings of coroners are not published or shared and recommendations are not monitored. There should be a mechanism to implement, monitor and subject to public scrutiny action taken in response to coroners' findings. All parties involved in the inquest should be kept informed of progress.

Coroners should inform the DCA on an ongoing basis of the content of any reports they make. These should be collated into an annual report to Parliament from the DCA setting out coroners' reports and suggestions for change under department-specific headings. Parliament should then ask the relevant department to report on what action has been taken. The DCA should notify investigation and inspection bodies of coroners' reports (see chapter 7).

5.4.2 c Perception of bereaved families of a lack of follow-up

The lack of follow-up action after the inquest can be incredibly frustrating and distressing for bereaved families, particularly if they feel that the inquest will not prevent future deaths occurring in similar circumstances. Many of them have struggled through the lengthy, painful and intrusive process motivated in part by a hope that the same thing does not happen to another family. The failure to ensure that they are informed of how the authorities have responded to the problems identified during the inquest can undermine the whole experience.

> 'It was an ongoing battle for almost three years. The coroner and HM Prison Service place no emphasis on the inquest as a form of learning and prevention.' [Family of a man who died in prison]

> '[I was] pleased the new governor had quite a long talk with us, she knew her job, said she would do her best to prevent this happening again, seemed genuine.' [Family of a man who died in prison]

> 'We felt exhausted and very saddened to see the lack of humanity displayed by people charged with the care and protection of

children. We were frightened to know that those same people would return to work with vulnerable children with no apparent recognition of their failings.' [Family of a child who died in a young offender institution]

5.5 Concluding remarks

The inertia within the current coroner service exerts such a powerful force that even measures which pull in a different direction from the prevailing culture are insufficient to deliver a 21st century service. In practice the position remains that families' legal rights in proceedings are restricted; the inquiry is not for them; the administrative framework is not directed at their full inclusion in the process; and they are not fully recognised as stakeholders with an interest in the final outcome.

The question of the independence of the inquest system has been deeply problematic and has contributed to families' distrust of, disappointment with and alienation from the whole process. Its independence can been seen to be compromised in part because of its staffing structure – many coroner's officers are still seconded police officers – and in part for historical reasons, because of its reliance on unsatisfactory and insufficiently independent investigations into custodial deaths, and its close working relationship with the police and recently the Home Office. It is perceived by many families bereaved by a death in detention as another arm of the state.

Moving government responsibility for coroners from the Home Office to the Department for Constitutional Affairs (June 2005) has started to address this problem. The potential neutrality of a reformed coroner service, properly staffed and resourced, with non-police personnel located within a national coronial service would enable it to guide families, provide information and refer them dispassionately to additional complementary services.

It is clear from comments from bereaved people that many felt surprised by aspects of the inquest and this caused them more distress. The experiences of families illustrate how far the service is from providing the necessary basic information to bereaved people. The standards fall far short of service level objectives set out in the Model Coroners' Charter in 1999 – suggesting inadequate training, monitoring, reporting and complaints mechanisms.

The Charter was described by the Home Office as containing the "minimum information which should be provided [to families] about the coroner service and its standards" adding however that "there is no reason why additional relevant information should not be provided".[36] The Charter provides guidance on a number of issues including: sensitivity to faith and cultural traditions; the treatment of bereaved people with courtesy and sympathy; the provision of clear information; time limits to be adhered to in responding to requests

36. Circular No 46/1999: *Coroner Service: Model Coroners' Charter,* 1999, para 14.

and clear information about who bereaved people can contact. It states that "every effort will be made to avoid causing any additional distress to close friends or relatives of the deceased".[37]

> 'Families should be treated with respect and not treated as criminals themselves or patronised by coroner's officers.' [Family of a man who died in prison]

The status of this Charter is unsatisfactory as it is only a guide. The Department for Constitutional Affairs website stated in March 2006: "This coroners' model charter describes the sort of services which may be available from the coroner for your area. *He or she is not obliged to provide these services either in full or in part* – many have produced their own charter which is available from the coroner's office. The aim of the model coroner's charter is to show what bereaved people and other users of the service can expect from coroners and their staff. It covers post mortems, procedure before, during and after inquests, the role of jurors and other areas such as how to give feedback, and to make complaints" (our emphasis).[38] The fact that there is no obligation to abide by this charter potentially renders it meaningless.

In February 2006,[39] the government announced how it intended to reform the inquest system. It proposed standards of service to be set out in a coroner's charter that will ensure bereaved people understand the coroner system and their rights within it and better information on support and bereavement services will be made available. The coroner's charter needs to include within it a commitment that the coroner service will treat all bereaved families equally regardless of the circumstance of death. The charter should have legal effect so it is not just a statement of intent; it should be enforceable.

The stated aim of the government is that these standards will be met by better regulation and leadership of the service via a new Chief Coroner who will also have the power to commission audits and inspections.[40] We are not convinced that this approach is rigorous enough to deliver the fundamental service changes that are required. Unless the whole service is restructured and better resourced it will still fail to provide the "better service to bereaved people"[41] envisaged by the government.

We are concerned that any new system does not repeat the mistakes of the past in leaving a triangular accountability structure between local authorities, the Lord Chancellor and the Department for Constitutional Affairs that makes it difficult to monitor, quality assure, train and complain about, or indeed remove those whose practice is poor. We are very aware that there are examples of good practice but that these are entirely dependent on the traits of the individuals involved rather than the framework and systems within which they operate.

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37. *Model Coroners' Charter,* 1999.
38. http://www.dca.gov.uk/corbur/coron04.htm
38. *House of Commons Hansard* debates for 6 Feb 2006 607 – 18.
40. *Coroners Service Reform Briefing Note*, 2006.
41. *ibid*, p2.

Despite the changes brought about as a result of legal reform, parliamentary lobbying and campaigns fought over the conduct of investigations and inquests into deaths in institutions, the current system is still insufficiently resourced and is failing to perform its preventative function, which is to ensure a decline in preventable deaths. The process is still too clouded in suspicion and defensiveness; does not allow for discussion of wider policy issues; does not ensure accountability of those responsible at an individual and institutional level and does not enable an honest and open approach to ensuring changes are made to prevent future deaths in similar circumstances.

Recommendations

A reformed inquest system

12. The Coroners Act and any secondary legislation and codes of practice should be amended[42] to require:

a. an inquest to be held with a jury where there is a death of a detained patient, of a child imprisoned in a secure training centre or of a detainee in an immigration detention centre;
b. an agreed mechanism to ensure that the jury is made up of peers of the deceased and that different parties can make representations on jury selection;
c. full mandatory disclosure of all information irrespective of whether the coroner intends to call witnesses, and clear rules about when and how it will be made;
d. a regional structure for the coroner service with the regional coroner having sufficient experience and knowledge to preside over all deaths in detention cases;
e. compulsory continuing training for all coroners;
f. provision of regular updates on changes in coronial law;
g. a casework management approach in inquests into deaths in custody with clear timetables set out at the initial opening of the inquest, subject to regular review;
h. a mechanism to implement, monitor and subject to public scrutiny action taken in response to coroners' findings and inquest juries verdicts and to inform all parties involved in the inquest of progress.

13. In the short term complex and controversial custody death inquests should be heard before a judge sitting as a coroner. Consideration should also be given to allocating additional resources in the form of full time deputies to coroners' jurisdictions with the most prisons and other places of detention to address the problem of delay.

42. These are discrete recommendations that arise directly from the report. For INQUEST's response to the draft Coroners Bill see www.inquest.org.uk

Administrative issues

14. Inquests should be held in accessible well-equipped buildings to ensure:

a. families have access to a private room;
b. sufficient space in the court to seat all properly interested persons on different rows;
c. access to office facilities for all legal representatives;
d. collation and numbering to enable everyone to work from the same bundle of documents at the hearing;
e. standardised recording of proceedings with free transcripts available to all properly interested persons.

Legal representation for families

15. In the long term:

a. there should be an automatic right to non means tested public funding for legal representation of bereaved families;
b. the Law Society should consider setting up an accredited panel in conjunction with the INQUEST Lawyers Group.

16. In the short term decision makers at the Legal Services Commission Special Cases Unit should:

a. be trained by relevant organisations to understand the context and impact of a death in custody on a bereaved family;
b. be required to shadow a solicitor from the ILG in order to gain a better understanding of the nature of an inquest case and the type and quantity of work involved.

Chapter 6: The impact of a death in custody and inquest

"Death and bereavement inevitably touch us all in some way and when a prisoner dies the family is bereaved in the same way as anyone else. But there is an added dimension to a death in prison. Firstly family and friends do not just lose a loved one; they lose him or her in very painful circumstances, separated from them and in conditions that they do not fully appreciate.… Thus the impact of a death in custody is compounded by a number of additional factors and emotions, which must be acknowledged, but are difficult to understand objectively." (HM Chief Inspector of Prisons)[1]

> 'This has affected my family in lots of ways. Our relationships have suffered, some unable to cope at work and have lost their job. You are expected to carry on as normal but one cannot. We've been blaming each other, ourselves. It's always there in the back of your mind. We will never get over this.' [Family of a man who died in prison]

'As a conventional, middle class, middle aged couple we felt dismayed by the performance of the public services which we had for most of our lives considered to be pillars of society. The impact on us was that when it came to a crisis the truth, sensitivity to individuals bereaved by such a tragedy and the community's need to learn the real lessons in order to help future generations would all be sacrificed to the self-protective interests of bureaucratic public institutions.' (Audrey Edwards)[2]

> 'We thought that we were going insane, couldn't understand what was happening to us, what had happened to my son. INQUEST has supported, enabled, educated and empowered and restored our faith in justice. We were given back our voice.' [Family of a child who died in a young offender institution]

6.0 Introduction

In this chapter we discuss the emotional impact of a death in custody, its investigation and the inquest on family members. We consider the specific nature of this kind of bereavement and how it involves both complex grief and legitimate anger. We discuss the options available to meet families' emotional needs. We consider how getting involved in working for change and taking action about the issues that have caused families anger and loss has helped.

6.1.1 Impact on the family of the death

Whatever support mechanisms are in place, the experience of a death in custody and an inquest will always be traumatic. "For most people the normal expectations are that they will live the allotted three-score-years-and-ten … that parents will pre-decease their children [and] that dying persons will be able to deal with any unfinished business and

1. *Suicide is Everyone's Concern: A Thematic Review,* 1999, p3.
2. *No Truth No Justice*, 2002, p73.

breathe their last breath surrounded by their loved ones … It is usually some kind of unexpected and traumatic death that requires people to be involved in the coronial system. The survivors or victim's family/friends have to be understood from that perspective."[3]

A death in custody is an event that is remote in the expectations of the bereaved. This contrasts with a natural death, for which relatives may have had time to prepare themselves psychologically and emotionally and to consider practical matters to be addressed after death. It is also a death that may be experienced not just as unexpected but as deeply shocking because other people had both jurisdiction over and a duty of care towards the deceased.

That the bereavement is completely unexpected means firstly that it is more intensely traumatic in the period immediately after death; and secondly that it can have more serious long-term effects. It is important that post-death investigations do not contribute further to the family's distress and have a subsequent negative impact on their physical and mental health.

6.1.2 Impact on the family of the investigation processes

The circumstances of deaths in custody mean families are involuntarily engaged in the investigation and inquest system. They hope their questions will be answered and their concerns addressed. Instead they can be left feeling that they have been further damaged by the investigation and inquest which in turn exacerbates their anger and grief.

Post-death procedures can either cause more distress or provide support to the bereaved family. The small number of families who describe an experience that was more positive shows that the investigation and inquest process do not need to make it worse. Unfortunately, the majority of families describe a range of strong emotional reactions most of which are negative. At the end of the process families felt:

> 'Bullied/intimidated and subjected to unnecessary suffering.' [Family of a man who died in prison]
>
> 'Hurt, angry, depressed, lost, bitter. Words cannot describe.' [Family of a man who died in prison]
>
> 'Gutted, let down, disillusioned, conned, angry, bitter. Felt it had all been a waste of time. My daughter suffered tremendously and acknowledgement of this fact alone has not been accepted by anybody yet. Justice has not been done nor seen to have been done.' [Family of a woman who died in police custody]
>
> 'Let down and feel laws can be bent by people in power.' [Family of a man who died in prison]
>
> 'Defiled.' [Family of a man who died following a police pursuit]

3. 'Coping with Grief', 1992, pp186-187.

> 'Very disappointed. We were told we would have all our concerns and questions answered. We had none.' [Family of a man who died following a police pursuit]

As described in earlier chapters, accessing the investigation and inquest process is often difficult. But for many families it is only when they have answers to their questions about the circumstances of the death that they can begin to grieve.

> 'There was a great sense of relief as [the inquest] was very emotional. Anger then set in about a month later towards the prison/medical staff for their part in my brother's death.' [Family of a man who died in prison]

In some cases obtaining answers has required attendance at numerous court hearings and even obtaining a second inquest. For others the lack of access to appropriate advice and support has damaged their ability to move on, as they have not only been victimised by the death but also by the investigation and inquest system itself.

> 'In all of this, I have been treated badly by the penal authorities, as if I were the guilty party. Nobody has remembered that I am the victim.' [Family of a man who died in prison]

> '[I felt] like nothing. My brother's death was just swept under the carpet. I felt like killing the duty governor.' [Family of a man who died in prison]

> 'Please help set up a procedure to ensure that in such tragic circumstances nobody is dealt with as badly as I have been.' [Family of a man who died in prison]

> 'Very upset and sad in fact from day one of our son dying there has been a lot of lies and cover up. We feel that we will never find the truth about how our son died or where all his personal effects are … all we got back was a few clothes, shoes.' [Family of a man who died in prison]

It is harder to move through grief if families are not empowered to engage with the legal process. Both statutory and voluntary agencies with which bereaved families are in contact should ensure that all possible steps are taken to provide specialised and informed advice, resources and assistance.

6.2 The specific nature of bereavement in this context

> 'We are not ashamed of R, his addiction is an illness and one for which he was undergoing treatment. To the prison he may well have been just another drug addict but to us, he was a son, a brother, an uncle and a brother in law. Surely you can understand why we would want to know how he could come to die of pneumonia whilst in prison.' [Family of a man who died in prison]

> 'There is so much that is bad where the families of the victims are concerned, there needs to be a lot more support to families. The stigmas attached to families when their relatives die in these horrible circumstances cause untold damage.' [Family of a man shot dead by police]

Differences in bereavement are academically and clinically recognised and this has led to the development of different approaches to assist bereaved people. However, in our experience the particular issues relating to the aftermath of deaths in custody, including legitimate anger, are not widely understood by professionals.

Anger and a search for blame are common reactions to grief, which are amplified when the death is sudden and unnatural and even greater when it takes place in a closed institution or involves the police. Families will inevitably feel angry, and suspicious of the institution where the person died and of related official organisations.

Attempts to understand grief following violent death have often overlooked the anger caused by the system of investigation, the inquest and the uncoordinated approach to prevention. Counsellors tend to focus on helping a person acknowledge and express their anger, aiming to defuse it. Instead we think that counsellors working with families bereaved in this context need to understand and work with the whole range of feelings of anger that have been generated by the death and to recognise the legitimate anger the family may have both about the way their relative died and how they have been treated in its aftermath.

As June Allan has pointed out: "To defuse the anger of a bereaved person whose rights have been curtailed in some way may deny them legitimate recognition of their grievance and may even fuel their anger or despair. Although there are many examples in practice of the channelling of anger towards positive social or political ends, the counselling literature largely tends to continue to view anger in grief as an internal process, to be acknowledged, expressed (ventilated) and defused. The assumption here is that the grieving person's anger is an internal matter, to be dealt with internally, even when there may be a justifiable external cause for the person's anger which leads to a strong sense of injustice and being treated unfairly."[4]

Those bereaved by death in custody will always be, as a group, at higher risk of suffering severe grief trauma than those bereaved by expected death. The nature of their grief will include elements of anger specific to their situation.

The well-developed counselling and support services run by some states in Australia could be used as a model for a similar approach here. For example the services offered may involve "sitting down with family groups within a few days of the death occurring to explain normal reactions to grief and loss, and assist persons who may have been exposed to trauma; speaking to groups of counsellors about the

4. *Being angry: Advocacy, social action and the bereaved,* 2005, p2.

coroner's process, and issues, which might affect people recently bereaved in sudden or unexpected circumstances; providing advice to parents as to how they should explain a sudden and unexpected death to children."[5]

Families have also expressed concerns about the lack of support available to children and young people whose parent or sibling has died. Grandparents have reported a lack of both emotional and practical support available where they have been left as the sole carers of their son or daughter's children.

6.3 What support is available

In this section we look at how bereaved families have sought to meet their emotional and practical needs, and discuss the options available. We look at:

a. bereavement counselling and other sources of support
b. support groups/networks
c. the role of INQUEST

Families have described how they felt at different stages of the process. Different families and different family members with their unique experiences may require a variety of responses.

It is important that those providing support consider how they respond: some agencies seem to respond to articulate and persistent families who are willing to complain but risk overlooking the many isolated and silent families who find it harder to ask for help. The coroner service, investigation bodies, health professionals and bereavement services need to be aware that it is not possible to set up one model that will meet every family's needs.

6.3.1 Bereavement counselling and other sources of support

Very few bereaved families knew how to access advice and information about bereavement counselling and less than a third of families received any counselling. Where counselling was obtained it largely appears to have been arranged by families privately and therefore independently of public health or social services. Those who did access help arranged by others did so primarily through their GP. In the absence of widespread access to bereavement counselling services, many families turn elsewhere for advice, assistance and support, e.g. to their GP, place of worship or workplace.

Of those who succeeded in obtaining bereavement counselling, more than two thirds felt that it had been helpful. Of the two thirds who did not receive it, the majority indicated that they would have liked to have had such counselling, had it been offered.

> 'It never goes away but trying to deal with it is very distressing. Police had counselling straight away. I was told police tried to get me help. I had to wait nine months before I got any, I did not know by then if I wanted it. You think you are dealing with it.

5. 'Managing Grief in the Coronial Setting', 2002, pp51-52.

I am now receiving counselling about once every three weeks.' [Family of a man shot dead by police]

Sadly some families reported that their counsellor had little or no understanding of the particular experience of a death in custody and subsequent inquest and found the process unhelpful and alienating.

Where the experience of the investigation process, coroner service and inquest has been bad, counselling does not appear to assist. Where the counsellors do not understand the particular difficulties experienced by families at some inquests this itself can have a negative impact. However where the post-death experience has been supportive, the inquest itself is an important process that allows families to move forward and counselling alongside this has proved helpful.

Casework example

The mother of a man who died in prison was told that her anger about the death of her son and not getting answers to her questions was just part of the normal grieving process and she needed to understand that in order to move on from her grief.

A number of states in Australia have specific counselling and support services attached to the coroner service of the kind which is completely absent within the current system in England and Wales. In Victoria there is a support and counselling service which provides the kind of support we described in chapter 3 that could be provided by a Family Support Worker, for example "running inquest information sessions, where persons whose loved one is subject to an inquest are invited to come and learn about what will happen at the inquest; assisting families in explaining the contents of an autopsy report or coroner's finding."[6]

Casework example

Another family member was told that she needed to let go of her anger despite the fact that over two years after the death the inquest had not been held and she had had none of her questions answered.

Bereaved people should be entitled to referrals to legal, social and health service providers, including voluntary sector providers. Mental health professionals and bereavement counsellors should be recognised partners within the coronial system. Where on-site assistance is not available, the court should have an index of suitable counsellors, psychologists and social workers who have the skills to deal with this kind of complicated grief.

6.3.2 Support from others with similar experiences

Many families are comforted when they realise they are not alone in their experience and it has often helped them to talk to others in similar circumstances.

'A family from North Wales got in touch with us. They had lost their son in similar circumstances. They were very helpful as they

6. 'Managing Grief in the Coronial Setting', *op cit*, p51

> knew what we were going through. We've kept in touch ever since. It was helpful to understand that many families had suffered in a similar way and that there is a pattern of failure by the establishment generally to properly investigate and apportion blame when deaths occur in the care of the state.' [Family of a man who died following a police vehicle incident]
>
> 'I telephoned many families and was devastated to learn how little help they had received.' [Family of a man who died in prison]
>
> 'I met other family members at meetings in London. This was very helpful. Their experiences being similar, they have understanding of what is happening inside you. I met some of the bravest and most dignified people ever.' [Family of a woman who died in police custody]

However, this mutual support should not be relied upon exclusively or be seen as a substitute for professional support, even where it is helpful. It is not always appropriate to expect other families to provide the support needed and not everyone finds the same mechanisms supportive. Some people prefer to deal with their experience privately or can find listening to other families' experiences more distressing.

> '[We were put in touch with other families], but it was not helpful.' [Family of a man who died in prison]
>
> 'We were not in any contact. After the inquest was over, the barrister suggested a family going through a similar inquest who lived in Liverpool, however we declined to meet this family because I felt it was time to grieve for my son now we had had the verdict.' [Family of a man who died in prison]
>
> 'I expect this [contact with other families] could happen but my energy levels are so low, I would not take this up.' [Family of a man who died in prison]

Many are unable or unwilling to access support from others in similar circumstances and find it hard to live with their isolation and despair. It is in these kinds of cases that input from statutory agencies is most urgent.

Assistance from official agencies should continue throughout the many months or years before the legal processes are complete, when support available from family and friends may naturally diminish given the demands of everyday life and the need for those more remote from the death to move on. Rynearson comments: "People … find they are uncertain about how to give support in a case of unnatural death. Many survivors talk of themselves feeling like the victims, becoming isolated and even feeling like others are avoiding them."[7]

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7. 'Psychological Adjustment to Unnatural Dying', 1987.

In chapter 3 we noted the limited understanding government and related agencies have of the specific and ongoing needs of families bereaved by deaths in custody. There is little support and guidance available from statutory agencies and this must change in a reformed system. Appropriate ongoing support must be available and follow-up communication about action being taken where the death has occurred in an institution must be provided. Family Liaison Officers, Family Support Workers, counsellors, psychologists and social workers should be trained to understand the investigation and inquest systems and the complex responses of people bereaved by a death in custody.

6.3.3 The role of INQUEST

> 'The efforts made by INQUEST on behalf of, and with the families they get involved with, go beyond the call of duty. Without them, the whole death in custody process would be insurmountable. With INQUEST there is at least a chink of light.' [Family of a man who died following contact with the police]

INQUEST's casework priorities are deaths in prison, police custody and in immigration and psychiatric detention. It is at the forefront of uncovering patterns and trends, both in terms of the treatment and care received by the deceased in custody and the experience of bereaved relatives following the death.

Its service enables families to access legal, practical and emotional support and guidance at the earliest stage. This means they can effectively participate in the process as they are guided and encouraged through the maze of agencies and professionals involved.

> 'Extremely useful. Could not have gone through the varying processes without help, advice and support of INQUEST.' [Family of a man who died in psychiatric detention]

INQUEST's casework protocol requires staff to be non judgemental, maintain equal opportunities standards, be aware of conflict of interest issues and at all times maintain the confidentiality of legal and personal information.

Caseworkers have contact with family members from very shortly after the death (if the family is appropriately informed about the organisation), referring them to lawyers from the INQUEST lawyers group, working with the legal team during the investigation and preparation for the inquest. In some cases they accompany families to meet investigators and attend the inquest.

> 'A member of INQUEST also gave us support once the court sittings started. They also showed their support through contacting the press.' [Family of a man shot dead by police]

INQUEST encourages families to participate in the process even where they are reluctant to do so due to hostility towards anything connected with state institutions. Caseworkers can mitigate the worst

suspicions and conspiracy theories by providing advice and acting as a conduit between the family and the various official agencies involved.

'A family is never sure with a Family Liaison Officer whether what they say will be taken down and used in a statement. They know that they can speak to me in confidence, that I will advocate for them all the time and there will be no conflict of interest.' [INQUEST Caseworker]

> 'We would never have coped without them – the caseworker working with us was so kind and genuinely cared.' [Family of a child who died in a young offender institution]

Families can be put in touch with others who can offer support as a result of their own experience through INQUEST's family support network[8] and Family Forum.[9]

> 'Words cannot express how important INQUEST was to me and my family – your help and professionalism were excellent. In the year-long battle we had of going to the Coroners Court, we could not have coped without your help.' [Family of a man who died in prison]

6.4 The role of working for change in coming to terms with loss

INQUEST has a unique body of knowledge from which to comment on deaths in custody and the issues they raise. In many cases the organisation will raise key issues with relevant agencies, government departments, MPs and other interested organisations. Recommendations for reform come from working with families following a contentious death. In this way the experience of casework directly informs the lobbying and policy work and the collective experiences of bereaved families are taken forward.

INQUEST assists and empowers families to access policy makers and politicians. This approach has been recognised in the recent academic discussions of grief: "Where anger can be seen to be a legitimate response to external circumstances that cause bereaved persons to experience a lack of respect or worth, or more disturbing, a curtailment of their human rights … advocacy and social action are important and legitimate forms of action and support to be considered…"[10]

Casework example

The family of a man who died in police custody approached the local Race Equality Council after the death of their son. The IPCC had not passed on information about INQUEST. On contact with the family INQUEST arranged for a solicitor and also a second post mortem. We sat with the family and spent a number of hours going through the investigation process and helped arrange support from other families who had found themselves in a similar situation.

8. An informal network of families prepared to offer telephone support to others.
9. Meetings for families hosted by INQUEST where they can raise concerns about their experiences and meet others.
10. *Being angry: Advocacy, social action and the bereaved*, *op cit*, p6.

> 'We have met other families at one or two INQUEST meetings. We also attended UFFC marches in London and met families. It does help speaking to others who have been treated as badly as yourself and they also give their support and strength for you to fight for justice.' [Family of a man shot dead by police]

This way of working with families has been an important feature of the organisation's work for many years. Following a meeting INQUEST organised with the then Chief Inspector of Prisons (now Lord) David Ramsbotham during his thematic review of suicide in prison in 1999, he said in his report: "We had a most moving and informative meeting with the relatives of nine prisoners who died in prison, whose courage in coming to meet with us I recognise and admire."[12]

INQUEST arranged meetings for groups of families with the team who conducted the Home Office fundamental review of coroner services in 2002, and with peers and MPs from the Joint Committee on Human Rights during their Inquiry into deaths in custody in 2004.

"We also held a private meeting with members of the families of people who had died in custody. They provided us with compelling evidence of failings throughout our systems of detention, and of the grievous personal consequences of those failings. The family members with whom we met, primarily parents whose sons and daughters had died, told us of their belief that the state had failed them in its duty of care." (JCHR)[13]

> 'INQUEST has provided excellent support. I shall be eternally grateful for the opportunity they gave me to talk to the Joint Committee on Human Rights and for their advice on a suitable solicitor.' [Family of a man who died in prison]

An example of what is involved in this way of working alongside families emerges from the experience of an INQUEST parliamentary meeting on deaths of children in custody. Each of the four families involved were at different stages of the investigation and inquest process. All the families spoke at the meeting about their experiences to an audience of MPs, peers, policy makers and voluntary sector groups alongside Lord Ramsbotham, Baroness Stern and an INQUEST co-director.

Casework example

The wife of a man who died in prison contacted INQUEST after a referral from the Prisoners' Advice Service (PAS)[11] five days after the death. She was in desperate need of advice as she didn't know what had happened to her husband and what was going to happen next. She had not yet met the PPO investigation team. She had a conversation with the governor who did not tell her about INQUEST. The family had found out about the death via the media. Police officers had visited the house subsequently and told her about the death but said they didn't know anything as they had simply received a fax asking them to contact her and inform her that her husband had died in prison.

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11. The Prisoners' Advice Service is a charitable organisation providing free and confidential legal advice to prisoners.
12. *Suicide is Everyone's Concern: A Thematic Review, op cit*, p5.
13. *Deaths in Custody: Third Report of Session 2004-05 Vol I*, 2004, para 6, p8.

The most recently bereaved family had never been to London before or travelled on a train. INQUEST staff members were able to understand what support the family needed in order to be able to accomplish what to them was a daunting, potentially overwhelming and emotionally difficult task. INQUEST helped by buying and sending train tickets to the family and meeting them at the station. The senior caseworker accompanied them in a taxi to Parliament, talking to them and putting them at ease. He was able to introduce them to the other families before the meeting started. Afterwards the families had lunch with INQUEST's co-director and casework team where all were able to talk about how the meeting went, what they wanted to do next, and also get to know each other.

Despite this approach being effective in taking the issues forward and supportive to bereaved families it also carries with it its own tensions. As INQUEST is a small organisation with finite human and financial resources it cannot meet the needs of all the families with whom it works. The organisation is frequently placed in the position of making difficult judgements about what it can do alongside families to take the policy issues forward and inevitably some feel let down and disappointed.

Guiding principles that underpin casework have been developed as a result of the organisation's direct work with bereaved families and have taken account of their feedback. The work is family-centred and casework driven and underpinned by these guiding principles:

Information – families should be given as much information about the process as possible.

Empathy – working alongside families, recognising that their unique experience and needs are crucial.

Continuity – families can work with the same person(s) from the beginning of the process to the end.

Respect and trust in the families and their experience – the work we do is guided by families and they have the right and the ability to voice their concerns, frustrations and anger at a flawed system.

Partnership – INQUEST maintains and develops links with other interested and involved organisations and individuals and uses their specialist knowledge.

Confidence – not everyone can or wants to work with bereaved people. It is a difficult and skilled job and INQUEST's staff are trained and supported to be confident and recognise their own and the service's limitations – it is acceptable to say "no".

Debriefing and support – staff must have sufficient space and time to talk through their feelings about their work and the issues it raises for them.

Independence and accountability – INQUEST is independent and receives no funding from the Home Office or the Department for Constitutional Affairs. We are accountable to those who provide funding for our service and also have a Community Legal Service quality mark.

These guiding principles could form the starting point for others to develop similar statements and approaches. As shown by their comments, the families we work with find this approach beneficial and demonstrates the importance of considering "grieving as not just a personal process, but also a social and political process in which professional responses to people's grief can channel and shape the experiences in particular ways."[14]

6.5 Concluding remarks

Official procedures which fail to recognise grief following traumatic death also often exacerbate it by failing to take account of the perspectives of the bereaved, whose needs and feelings as those most seriously and enduringly affected by the death should be the starting point of any investigation.

The coroner service does not have enough contact with bereavement services. Even where it does, the services available are rarely specialised enough to deal with the nature of grief following deaths in custody. If the coroner service and others do not pass on information about organisations like INQUEST they not only deny the family adequate bereavement advice but can also, by hindering their access to legal representation for whatever reason, worsen the impact of the inquest itself because the family will have a less meaningful experience of the investigation process as they attempt to deal with their grief at the same time.

All the bereaved people we work with had contact with the coroner service, most often very soon after death and well in advance of the inquest hearing. The coroner service would therefore appear to be the most appropriate partner for an integrated bereavement service, in terms of location and service users, particularly where Coroners Courts are housed in dedicated premises. There are already useful pointers and good practice models of the kind of resources that a new integrated coronial and bereavement service must provide at a minimum.

For many bereaved people facing inquests into deaths in custody the lack of understanding of their needs leads to unnecessary distress and further destruction of their quality of life. Early and well informed emotional support can make a huge difference. The counselling community needs to ensure it is equipped to help, that people know how to access its services and that it can refer families appropriately for practical and legal advice. It also needs to recognise the importance of acting for social justice as a potentially helpful and legitimate response to both deaths in custody and the procedures that follow such deaths. As Bill Rolston has argued, "the articulation of the needs and demands of victims of state violence has been a source of unease in a situation where the issue of victims has become

14. *Being angry: Advocacy, social action and the bereaved, op cit*, p3.

increasingly colonised by the language of social work, psychology and counselling."[15]

The way INQUEST has worked with bereaved people for 25 years has meant that families have been able to contribute to the fundamental changes that have taken place in the investigation and inquest system. Contributing to the survey that underpins this report has been a continuation of this process and we hope that this report will further the important and ongoing process of reform.

Recommendations

Support for bereaved families

17. The coroner service should ensure:

a. bereaved families are referred to appropriate legal, social and health service providers, including those in the voluntary sector;
b. mental health professionals and bereavement counsellors should be recognised partners within the coronial system;
c. the court has an index of suitable counsellors, psychologists and social workers with the skills to deal with the complicated grief that follows a death in custody;
d. adequate and accessible information is provided about the inquest process;
e. families receive follow-up communication about action being taken where the coroner has made a report under Coroners Rule 43;
f. Family Liaison Officers, Family Support Workers, counsellors, psychologists and social workers working with bereaved people should be trained to understand the inquest system and the complex responses of bereaved people to a death in custody and an inquest.

15. *Unfinished Business*, 2000, p xiii.

Chapter 7: Key proposals for reform and concluding remarks

"When we take this very serious step of denying people their liberties … we do so with certain safeguards. We do not strip these people of their legal rights or their rights as human beings … rather we believe that those in custody retain many of the rights that they held in civil society, rights which can and are upheld by the courts. What occurs within custodial settings rightly raises concern, recognised by the courts. Western liberal democracies do not ascribe to the arbitrary misuse of power by the police, prison officers or psychiatric staff. That is why such profound concern arises about deaths in custody and that is why so much emotion and anger is generated by the investigations into these deaths." (Professor Mick Ryan)[1]

7.0 Introduction

Throughout the report we have made recommendations and suggested improvements to current practice based on families' experiences of serious failures at each stage of the investigation and inquest systems following deaths in custody.

INQUEST's monitoring has shown how the state uses the inquest and not criminal prosecution for the public examination of even the most contentious deaths in custody. The government has also sought to ensure deaths in custody are exempt from proposed legislation on corporate manslaughter[2] which means a public body may contribute to the death of member of the public in a grossly negligent way and avoid criminal prosecution. Therefore the inquest assumes a crucially important role in ensuring accountability as the only official forum where a death in custody will be subject to public scrutiny.

Monitoring the investigation and inquest process has demonstrated that a significant number of cases reveal clear evidence of individual and systemic failings. Inquests repeatedly highlight the failure to implement existing guidelines on the care of vulnerable detainees. Recommendations made by inspection bodies alerting state authorities to the potential risks to the health and safety of people in custody are often not implemented and can result in further deaths or serious injuries. Despite critical investigation reports and detailed narrative verdicts returned at inquests highlighting systemic failings, action is rarely taken either at an individual or senior management level.

The vital contribution the coroner service can make to the prevention of further fatalities is hindered by the failure to take action based on the findings and reports that emerge from the investigations. We suggest that coroners should be allowed to inquire broadly into matters arising in these cases that are likely to result in recommendations conducive to public health and safety. To reduce the number of preventable deaths, the wider environment in which the death occurred needs to be analysed. To reduce unsafe practices

1. Opening speech to the Institute for the Study and Treatment of Delinquency (now Centre for Crime and Justice Studies) conference on Deaths in Custody 1997.
2. Corporate Manslaughter and Corporate Homicide Bill 2006-2007.

broader issues need to be explored than are currently permitted by the narrow remit of the inquest. Analysis of thematic issues could lead to important changes and save lives.

We remind readers of the threads that run through the report that have been articulated by families: the need to know the truth, for action to be taken to prevent similar deaths and for those responsible to be held to account.

We recognise we are writing this at a time when the draft Coroner's Bill has been published and will comment on that elsewhere but situate our proposals within the broad framework of the proposed reform.

The two proposals outlined below, if implemented alongside reform of the inquest system and the practice changes already suggested, could make a significant contribution to improving families' experiences, preventing further fatalities and achieving greater accountability.

Also emerging from the report are a number of issues that need to be investigated further; these are also outlined in this chapter.

7.1 Key proposals

Key Proposal 1: Improving the processes following the conclusion of the investigation and inquest into custodial deaths

Analysis, publication and action arising from coroners' reports and jury findings

The new system must produce a systematic way of learning from the investigations and inquests into custodial deaths. Currently, as we have discussed, the findings of inquests – the verdict and any r43 reports – are not published or shared and recommendations and responses are not monitored.

We believe the government could learn from the coronial system in Victoria, Australia[3] where the emphasis of the system is on death prevention. Any proposals for legislative reform need to include a clause that provides that the purposes of an inquest are:

(a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;

(b) to provide an effective mechanism for eliciting and challenging evidence; and

(c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.

Bereaved families tell us that while they know that the inquest cannot bring back their relative, if lessons are learned to prevent similar deaths it will have some meaning for them. Follow up action after an inquest is a fundamental part of an effective investigation and

3. *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, 2006.

that the state has a proactive role to play in effecting change when deaths occur in its custody.

Where a coroner believes that action should be taken to prevent the recurrence of similar fatalities, he or she should be under a duty – not a discretion – to report the matter to both the person who may have power to take remedial action and the Chief Coroner.[4]

There should be a duty on coroners to make recommendations whenever appropriate about preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.

The office of the Chief Coroner should prepare detailed guidelines and training for coroners in relation to the formulation of such recommendations

All coronial recommendations should be made publicly available and coroners empowered to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation.

The coroner should then be required to provide a copy of the response referred to in the recommendation above to: the senior next of kin of the person whose death is mentioned in the coroner's findings or their representative; a witness who appeared at an inquest into the death who is the subject of the findings; and any other person who the coroner considers has sufficient interest in the inquest or investigation.

The office of the Chief Coroner should have the power to call for such further explanations or information as he or she considers necessary in relation to the implementation of recommendations.

The office of the Chief Coroner to include in its annual report to Parliament: (a) a summary of all coronial investigations in which recommendations have been made; and (b) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or response.

Parliament should then ask the relevant government department to report on what action has been taken. There should be a statutory obligation on departments to respond within agreed time limits. They should be required to present an action plan.

A National Coroners Information System should be created to enable data on all inquests and their findings to be collated and available for all coroners to access. It should be complemented by a research unit established within the Chief Coroner's office with the capacity to properly utilise the National Coroners Information System database to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation.

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4. Coroner Reform: The Government's Draft Bill 2006 section 56.1.

The Chief Coroner should also notify investigation and inspection bodies of coroner's reports and jury findings as they happen and ensure they receive the annual report.

There should be an obligation for those who receive reports to respond not only to the coroner, but also to the investigation bodies and the family concerned. Consideration should be given to a mechanism whereby such reports must be acted upon or explanations published for why reasonable action has not been taken.

The investigation bodies should be required to incorporate any coroner's reports and jury findings into their final report on each individual case. Both the IPCC and PPO should collate relevant reports and jury findings, publish and circulate them and use them to monitor outcomes and improve practice.

Key Proposal 2: Establishing a Standing Commission on Custodial Deaths

However, the inquest and the investigation and inspection bodies cannot address the issues raised by deaths in custody in the manner necessary to ensure action is taken. We reiterate INQUEST's recommendation for a Standing Commission on Custodial Deaths[5] which could systematically address the question of deaths in custody. It would bring together the experiences from the separate investigation and inspection bodies established to deal with the police, prisons and other deaths in detention. There are many shared features that arise again and again in deaths in custody that often raise issues that go beyond the narrow remit of specific government departments, state agencies and custodial agencies. An overarching body could look beyond individual deaths and identify key issues and problems arising from the investigation and inquest process and monitor the outcomes and progress of inquest findings. It could look at serious incidents of self-harm or near deaths in custody where there is a need to review and identify action to be taken to prevent similar incidents.

The Standing Commission would develop policy and research, disseminate findings where appropriate and encourage collaborative working. Best practice established in one institution could be promoted in the other institutions and new policies designed to prevent deaths could be drafted and implemented across all the institutions. It could also act as a check and balance on the investigation bodies themselves.

The Standing Commission would play a key role in the promotion of an ethos of human rights in regard to the protection of people in custody. It would promote measures to prevent or minimise the risk of future violations of article 2 of the Human Rights Act. It would have an active interventionist role and powers to hold a wider inquiry where it identified a consistent pattern of deaths. Such an inquiry

5. *Deaths in Custody: Redress and Remedies, 2003; Deaths in Custody: Third Report of Session 2004-05 Vol II,* 2004, Ev150*; In the care of the state?*, 2005, p105.

could provide a platform for an examination of broader thematic issues as well as issues of democratic accountability, democratic control and redress over systemic management failings that fall outside the scope of the inquest.

The Standing Commission would have an independent secretariat and a board which would include representatives from community, family and other interested groups. It would not reproduce the work of already established investigation bodies but would be empowered statutorily to intervene in individual inquests or court cases where appropriate as an interested party. This could be particularly relevant following a death in custody where there is no traceable or interested next of kin.

There has already been interest and support for the idea of a Standing Commission. In the concluding remarks of the report of the Zahid Mubarek Inquiry, Mr Justice Keith commented:

"The death of Zahid Mubarek was just one of the many deaths in custody which occur every year. In the overwhelming majority of them, the prisoner commits suicide. But there are lessons to be learned from every death in prison. That is why bodies such as INQUEST, which provides legal advice and support to the friends and families of those who die in custody, have been pressing for a standing commission on deaths in custody."[6]

During the parliamentary Joint Committee on Human Rights Inquiry into deaths in custody, the then chair Baroness Jean Corston asked many of their witnesses including the Mental Health Act Commission, the Chief Inspector of Prisons, the Prisons and Probation Ombudsman and the Independent Police Complaints Commission for their views on INQUEST's proposal for a Standing Commission. This indicates that the JCHR viewed the idea of the Commission as worthy of further exploration. Their principal conclusion was that there was a need for "a central forum to address the significant problem of deaths in custody" and that a permanent "cross-departmental expert task force on deaths in custody" should be established.[7]

We are pleased to see that the idea of a Standing Commission is being taken seriously. It is distinct from other initiatives such as the Ministerial Roundtable on Suicides and Self Harm and the Forum for Preventing Deaths in Custody which have been established with more limited objectives and without significant resources or powers. They are not a substitute for a well-resourced overarching independent body with specific statutory powers.

The principal advantage of the Standing Commission over existing remedies is that its power and scope would not be limited to individual deaths in custody. Its focus could also contribute to wider policy considerations as many of the deaths are part of a pattern relevant to policies on drug and alcohol use, homelessness, mental health, crime prevention, combating racism, penal policy and policing.

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6. *Report of the Zahid Mubarek Inquiry,* 2006 Vol 1, para 63.4, p551.
7. *Deaths in Custody: Third Report of Session 2004-05 Vol I* , 2004, paras 375-376, p107.

7.2 Directions for future research and further work

We have identified a number of outstanding projects and questions that deserve INQUEST's further attention. One of the most pressing is developing and expanding our proposal for the Standing Commission. Another need identified is achieving better co-ordination of the voluntary sector working on bereavement issues and contentious deaths. The additional questions that emerged whilst writing the report that require further work include:

a. Is there a need to consider a specialist approach to inquests into deaths in detention or in other circumstances that engage article 2 of the Human Rights Act?
b. What harm is caused to bereaved families by delays in the inquest and investigation systems and their grief being on hold?
c. What is the effect on children of death in custody of a family member, what are their specific support needs, what help is available and what is the role of grandparents and other carers when parents die?
d. In other jurisdictions[8] discussion has begun on alternative approaches to the aftermath and investigation of contentious deaths. The question has been posed about the possibility of viewing the inquest as a healing or therapeutic process that could address, in the broadest sense, the harm caused by the death. Can principles of restorative justice be applied in the aftermath of deaths in custody?
e. What can be learnt from the comparison and analysis of the approach to deaths in custody in other countries?

7.3 Concluding remarks

Until bereaved families and their concerns are treated with greater respect and there is acknowledgement that an open examination of all the facts surrounding a death in custody is in the interests of everyone involved, there will not be an adequate focus on policy change to prevent more deaths occurring in the future.

Bereaved families tell us that what they want is for the process to result in changes which will ensure another family does not have the same distressing experience. Where there has been wrongdoing or mistakes have been made families want an admission, an apology and to see those responsible brought to account. Where the state's duty of care towards people it takes into its custody is violated they want consideration to be given to prosecution of those responsible.

The systems of investigation must continue to evolve to ensure that changes are made which contribute to preventing further similar deaths.

Deaths in custody and their investigation expose to scrutiny some of the most brutal and worrying aspects of the treatment of detainees within the criminal justice system. In uncovering these issues we come

8. *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06,* 2006 *op cit*.

face to face with the secrecy and authoritarianism inherent in that system. Detainees and their families are frequently treated with a lack of respect irrespective of issues of gender, race and class.

However deaths in custody cannot be considered in isolation from the contemporary criminal justice system – police, courts, judiciary, prisons – and issues of poverty and inequality as these all impact on deaths in custody. To understand how, it is necessary to move away from discussion of individual pathological conditions of these cases and broaden the analysis to take into account the impact of social policy; clearly that is beyond the scope of this report.

"The advanced democratic state, supposedly underpinned by the checks and balances of inter-related, formalised processes of legal, political and professional accountability, claims transparency for its public institutions. [But] inquiries into specific cases and more general allegations of inhuman and degrading treatment have been hindered by powerful staff and management interests." (Scraton)[9]

Unlocking the truth about deaths in custody sheds light on the way we treat some of the most vulnerable men, women and children in society. It is important that we recognise, scrutinise, criticise and argue for reform of the way the state deals with deaths in custody as these processes are an indicator of the condition of its democracy.

9. 'Lost Lives, Hidden Voices: "Truth" and Controversial Deaths', 2002, p108.

Appendix A: A best practice case study

Throughout the report we have described the experiences of bereaved families as the investigation process and inquest system evolves. Here we look at what could be done to improve families' experiences: both immediate change that can be made without legislation and changes that require new legislation.

We describe the journey a family could take through the investigation and inquest system following a death in prison. We use our knowledge of existing good practice, the way the system works and the constraints it operates under to show that it is possible to address some of the concerns and bad experiences described in the earlier chapters prior to any legislative change. There are many examples of existing good practice which, if adopted as standard, could result in a significantly improved service.

We also imagine a reformed system and describe what could then happen. We base this appendix on an imagined case but suggest that the process might be a useful tool to be adopted by those tasked with improving the current system.

[***Text in bold italics presents the details of the imagined case study;*** **text in bold identifies various stages of the process;** normal text sets out what could happen ideally under the current system; *italic text indicates what a reformed system could achieve.*]

Death occurs in custody

A young man aged 21 is found hanging in a prison health care centre.

What could happen ideally under the current system:	What else a reformed system could achieve:
Coroner is informed immediately and given family details.	*Regional/specialist coroner is informed and the Chief Coroner.*

Family notified of the death

What could happen ideally under the current system:	What else a reformed system could achieve:
The family is notified as soon as possible of the death and before information is released to the media.	*The family is told about the death by the Family Support Worker from the nearest Coroner's Court, accompanied by someone from the detaining authority and investigation bodies.*

What could happen ideally under the current system:	What else a reformed system could achieve:
The family is provided with accurate information about the death, sensitively delivered by trained support staff in person; this is followed up in writing.	
The family is provided with or signposted to adequate bereavement services and informed about independent sources of advice and support.	
It is explained to the family that the body of their relative is part of an investigation and under the jurisdiction of the coroner. They are told which Coroners Court is dealing with the death and told that staff from the Court will contact them. They are given a named contact within the service with whom to raise concerns.	
The family is offered the opportunity to meet a senior official and visit the scene of the death. They are given a named contact within the the Prison Service. They are advised sensitively about how belongings will be returned to them.	*Family Support Worker assigned, who provides details of lawyers accredited to work on death in custody cases and information about INQUEST.*

Before the post mortem, initial contact with the Coroners Court and access to the body

What could happen ideally under the current system:	What else a reformed system could achieve:
The family is contacted by the Coroners Court and told where the body is.	*A Family Support Worker tells the family where the body is and explains post mortem procedures.*
The family is provided with transport to the body and allowed reasonable access to the deceased. Family warned about any injuries and given an explanation for any viewing restrictions.	
It is explained to the family that in these circumstances a post mortem is mandatory and they are informed about what it involves when they are advised about their options in relation to tissue samples.	
Family notified of the date of the post mortem and of their right to have a representative present in time for them to arrange for an independent pathologist to attend the examination should they wish.	

What could happen ideally under the current system:	
The family is informed about their right to a second post mortem The family is given options about how they receive the post mortem report including the offer to have someone explain what it means.	

Legal advice

What could happen ideally under the current system:	What else a reformed system could achieve:
The coroner/coroner's officer encourages the family to seek independent legal advice and explains what a lawyer could do for them in these circumstances. Information about funding is provided. The family contacts INQUEST who arrange a solicitor.	*The FSW explains to the family the importance of legal representation and gives them details of members of the accredited panel of lawyers. Funding for legal representation is automatic and non means tested.*

Inquest formally opened

What could happen ideally under the current system:	
Family receive explanation about this stage of the process and are informed that the inquest will be adjourned until the investigation is complete.	

Investigation

What could happen ideally under the current system:	
Investigation begins within days of the death.	

No third party involvement established.

What could happen ideally under the current system:	What else a reformed system could achieve:
Family contacted by investigators to arrange a visit within days of the death. Family is asked where they want the visit to take place; if the venue is not their own home, travel is arranged or costs offered. Told they can bring a friend or lawyer if they want. Visit takes place within agreed timetable and family are given an explanation about twofold purpose of the meeting: a) to explain what the investigation is and what will then happen; b) to take initial statement from the family about their concerns.	*After two months the coroner holds an initial meeting with all interested persons including investigators and a provisional timetable is agreed.*

What could happen ideally under the current system:	
If the family has no lawyer with them the investigators explain that the second part of the task can take place at a later date if they want. If they are alone in the meeting they are asked if they have been given information about getting a lawyer and advice and support; if they have not they are signposted to INQUEST.	
Family is given accurate estimate of timetable of investigation and realistic assessment of resources available; told they will be kept informed of progress.	
Family kept updated about progress, documents disclosed to them in a timely manner so they are able to ask for particular issues to be investigated.	
Family is provided with documents as they are generated by the investigation.	
Family contacted periodically throughout the investigation by FLO/FLM for support.	

Draft report completed

What could happen ideally under the current system:	What else a reformed system could achieve:
Family contacted and meeting arranged with investigators to discuss draft report.	
Draft report given to family and/or their representative in good time to prepare for meeting.	
Individuals named in the report are not able to veto its contents or hold up process.	*Draft report remains a draft until after the inquest when changes are made to reflect evidence heard, verdict and any r43 reports included.*
A timeframe is agreed for completion of the final draft report.	

Hand over from investigation to inquest

What could happen ideally under the current system:	What else a reformed system could achieve:
Coroner's officer contacts the family to let them know that the coroner is beginning to organise the inquest hearing; again asks if they have legal representation and if not suggests they contact INQUEST.	*Decision made about which coroner will preside over hearing.*
Coroner organises pre-inquest hearing within one month.	*Timetable reviewed and amended if necessary.*

Pre-inquest hearing

What could happen ideally under the current system:	What else a reformed system could achieve:
Family and lawyer provided with resources in advance to attend hearing.	
At pre-inquest hearing the interested parties agree the oral and documentary evidence, make submissions about further evidence, including the need to ensure evidence is available from senior representatives of the Prison Service who can help the inquest on training, policy and procedure.	
The interested parties agree the issues and themes that will be explored at the inquest. Any difficulties about disclosure can be resolved and agreement sought about expert witnesses. The preparation of bundles for the use of the court, witnesses and interested parties is organised.	
Family invited to suggest expert witnesses.	
Family invited to meet the coroner and visit the Coroners Court…	*…(which is purpose built with canteen facilities, private waiting space, witness support service etc).*

Inquest

What could happen ideally under the current system:	What else a reformed system could achieve:
	The proceedings are taped and transcribed as a matter of course. Transcripts are freely available.
	Jury asked if they have any connection to police or Prison Service.
The jury are clearly informed of their task and allowed to ask questions at the hearing.	*Objections can be made to jury members and they can be removed.*
The coroner is aware of recent legal developments in human rights law.	
The jury is properly directed on how to return appropriate verdict.	
The verdict reflects the evidence.	
The coroner announces that he or she is making a r43 report to address any systemic problems and informs the court of its contents and that he or she will keep family informed of any response.	

The jury delivers a long report of findings after which the coroner delivers a conclusion to findings, comments and recommendations (which we have imagined below about a death in prison).

	What else a reformed system could achieve:
	1. The Prison Service owed a duty of care to prisoner X. *2. For ten years the prison service has been warned by coroners and the prison inspectorate about inadequate cell design, poor implementation of suicide prevention guidelines and risk assessment.* *3. These warnings had been given to the Prison Service over a period of many years and in this prison seven young men have died in this period.* *4. The present governor had made substantial efforts to improve cell design but had been hampered by lack of resources. However the implementation of guidance within the prison was poor.* *5. Ten years is far too long for the Prison Service to get its house in order, particularly when considering the life and safety of prisoners to which it owed a duty of care.* *6. The Prison Service contributed to the death of prisoner X because, despite all the warnings it had received in the previous decade, guidance had not been properly implemented and cell design remained inadequate.* *7. This is not the only way the Prison Service contributed to the death. Other problems are detailed in the seven page findings.* *8. The role of various prison officers, doctors and governors was comprehensively investigated during the inquest, and a number of shortcomings, areas of criticism and scope for improvement have been identified; however, on the recognized legal standard, those parties have not contributed to the deaths.* *9. Throughout the inquest, the importance of learning from the death so that the same errors will not occur again has been stressed. The positive outcomes from the investigation of the death will have consequences for other prisons and institutions of detention.*

Outcomes of the inquest

What could happen ideally under the current system:	What else a reformed system could achieve:
The investigation report is amended in the light of the inquest verdict and r43 report.	*The outcome of the inquest is recorded in an annual report collated by the Chief Coroner for anyone to consult and monitor trends.* *A report is made to parliament of all r43 reports and requirement that relevant public bodies/departments respond within a year.*
R43 reports and verdicts are collated by the relevant investigation bodies and published.	*R43 reports carry mandatory force and are acted upon or reasonable written explanation given for no action or for different action taken.*
Progress on r43 reports is fed back to all interested persons: coroner, family, investigating bodies, DCA.	

After the inquest

What could happen ideally under the current system:	
Family receive update on progress on r43 report if they wish.	

Appendix B: Information about methodology

This report is based on casework, surveys and questionnaires (of families, of legal practitioners, of caseworkers and of other voluntary organisations), meetings and consultations; the report draws upon the combined experience of INQUEST's staff.

All of the information in this report is supported by detailed documentary evidence held on our files; much of the information is already in the public domain and other information is available on our website. For further specific information about the questionnaires and other materials used to compile the report or about the cases referred to in it please write to us.

Casework

INQUEST defines casework as working closely with family members very soon after the death, referring them to appropriate lawyers, working with the legal team, attending the inquest and raising ensuing issues with relevant agencies, government departments and with MPs and other interested organisations. Over its 25 year history, this has allowed the organisation to amass a unique and expert body of knowledge which has directly informed its policy work and research, including this project, and places the organisation in a position to identify and comment on trends and patterns across custodial deaths.

Surveys

Five surveys have been conducted: two family surveys (December 2000 and July 2004); a survey of non-governmental organisations offering advice and support to bereaved families following a contentious death (December 2004); a survey of senior practitioners of coronial law (February/March 2005); and a survey of INQUEST's casework team (February 2005).

This report is mainly based on information provided by families during the second survey though data from the previous family survey provided background context. It also draws extensively on families' descriptions of their experience to INQUEST staff.

The family survey was a written questionnaire posted to families and contained a mix of quantitative and qualitative questions. 267

questionnaires were distributed and 158 were returned. There were eight sections dealing with the post-death process from being informed of the death through to after the inquest. The survey can be obtained from INQUEST.

We were conscious of the need to approach this work with great sensitivity and to be scrupulous in our conduct. We emphasized that participants' involvement was voluntary and strove to ensure that all had full awareness of the objectives of the project, the procedures to be followed, and the anticipated outcomes particularly in respect of publication of findings.

The caseworker survey gathered information from INQUEST's caseworkers. The questions were almost entirely open-ended, qualitative questions. The survey was carried out through face-to-face interviews.

The practitioners' survey was drafted in conjunction with INQUEST's caseworkers, who were able to advise on the most pertinent questions as a result of their experience attending inquests. The survey comprised 25 questions and was agreed with a senior solicitor working in the field of coronial law before being conducted. Data was gathered both by telephone or face-to-face interview and by written response to the questions.

Twenty-three respondents were selected on the basis of their experience in the field. We were concerned to ensure, as far as possible, that there was a balance between solicitors and barristers as well as an even geographical spread of respondents; this proved difficult, partly because of the concentration of legal professionals (particularly barristers) in London and partly because very few practitioners in England and Wales have significant experience of Coroners Court proceedings.

The organisations' survey was conducted by telephone. The survey covered the ease of getting through to an organisation, the advice given to people with legal problems relating to an inquest, and referrals made by organisations to people dealing with a particular type of contentious death. Most questions were closed, quantitative questions, although the survey also asked for general comments.

We made it clear that at any time during any interview (used with voluntary organisations, some legal practitioners and our caseworkers) participants could stop the process and that they were under no obligation to answer our questions.

Meetings

The report has drawn on meetings and consultations not attended exclusively for the purposes of this project but as part of INQUEST's ongoing policy work. We ensured that other participants of such meetings and consultations were aware of this and of the aims and objectives of the project.

INQUEST is a charity. The organisation's board of trustees was informed about the study and its objectives, and were kept up to date

Table 7: INQUEST CASEWORK 2000-2005

INQUEST – All prison, YJB and police custody cases 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Prison	35	40	49	60	70	72	326
Youth Justice Board (YJB)	0	0	0	0	2	0	2
Police	21	16	19	26	16	17	115
Total	56	56	68	86	88	89	443

INQUEST Cases – Youth deaths (21 and under) in prison/YJB custody 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Prison	9	13	5	12	8	12	59
YJB	0	0	0	0	2	0	2
Total	9	13	5	12	10	12	61

INQUEST Cases – Deaths of women in custody 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Prison	5	3	3	18	30	5	64
Police	0	0	1	1	1	2	5
Total	5	3	4	19	31	7	69

INQUEST Cases – BME deaths in custody 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Prison	8	6	6	4	12	17	53
YJB	0	0	0	0	1	0	1
Police	6	5	2	5	3	9	30
Total	14	11	8	9	16	26	84

INQUEST Cases – Prison 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Prison – self-inflicted	24	32	33	48	53	50	240
Prison – prevention	4	2	3	0	2	2	13
Prison – non-self- inflicted	5	5	12	11	14	14	61
Prison – homicide	2	0	0	0	1	2	5
Prison – control & restraint	0	1	0	0	0	0	1
Prison – other	0	0	1	1	0	4	6
Total	35	40	49	60	70	72	326

INQUEST Cases – Police 2000-2005

Type	2000	2001	2002	2003	2004	2005	Total
Police Custody	15	14	13	15	13	12	82
Police Shooting	2	2	0	3	0	4	11
Police Vehicle Incidents	4	0	6	8	3	1	22
Total	21	16	19	26	16	17	115

Source: INQUEST casework

on progress and provided support for the project in regular meetings with the co-directors.

Two researchers assisted the authors with administration of the project and the collection of data – Adam Barty and Lucie Wibberley. Dr Milena Nuti worked as researcher and assisted with the writing of the report.

In the period covered by this report, INQUEST has worked on 443 custody cases, providing advice and support to nearly 600 people whose loved ones have died in police, prison and other forms of custody.

References

Judgments

Edwards v UK (2002) 35 EHRR 19.
Jordan and others v UK [2001] 37 EHRR 52.
R v West Somerset Coroner ex parte Middleton [2004] UKHL 10.
R v Secretary of State for the Home Department ex parte Amin [2003] UKHL 51.
R v Secretary of State for Health ex parte Khan [2003] EWCA Civ 1129.
R v North Humberside and Scunthorpe Coroner ex parte Jamieson [1994] 3 All ER 972.

Legislation

Coroners Rules 1984.
Coroners (Amendment) Rules 2005.
Coroners Act 1988.
Access to Justice Act 1999.
Human Rights Act 1998.
Human Tissue Act 2004.
Corporate Manslaughter and Corporate Homicide Bill 2006-2007.
Coroner Reform: The Government's Draft Bill 2006.

Publications

Allan, J. (2005) *Being angry: Advocacy, social action and the bereaved*, paper delivered at the 7th International Conference on Grief and Bereavement in Contemporary Society.
Auld, Rt. Hon. L.J., (2001) *Review of the Criminal Courts in England and Wales*, London, The Stationery Office.
Coles, D. and Shaw, H. (2002) *How the inquest system fails bereaved people, INQUEST'S Response to a Consultation Paper by the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland*, London, INQUEST.
Coroners' Society of England & Wales (2002) *Practice Notes for Coroners,* Hampton, The Coroners' Society of England & Wales.
Cragg, S. (2004) *'Middleton & Sacker:* major development in inquest law*', Inquest Law* issue 7, May 2004, London, INQUEST.

Cragg, S. (2004) *Putting Middleton and Sacker into Practice*, London, Doughty Street Chambers.

Davis, G., Lindsey, R., Seabourne, G. and Griffiths-Baker, J. (2002) *Experiencing inquests*, Home Office Research Study 241, London, Home Office Research, Development and Statistics Directorate.

Davis, H. and Scraton, P. (1997) *Beyond disaster: identifying and resolving inter-agency conflict in the aftermath of disaster*, London, Centre for Studies in Crime and Social Justice/Home Office.

Department for Constitutional Affairs (2006) *Coroner Reform: The Government's Draft Bill*, London, The Stationery Office.

Department for Constitutional Affairs (2006) *Coroners Service Reform Briefing Note,* London, Department for Constitutional Affairs.

Department of Health (2003) *Families and post mortems: A code of practice*, London, Department of Health.

Edwards, A. (2002) *No Truth No Justice*, Hook, Waterside Press.

Glassock, G. (1992) 'Coping with Grief', Chapter 11 in H. Selby (ed.), *The Aftermath of Death,* Sydney, The Federation Press.

Goldson, B. and Coles, D. (2005) *In The Care Of The State?*, London, INQUEST.

Griffin, D. (2002) 'Managing Grief in the Coronial Setting' in *In Quest, The Journal of the Australasian Coroners Society Inc.* Issue 1, Victoria, The Australasian Coroners Society.

Hattenstone, S. 'We cannot take them at their word – "police sources" routinely vilify victims and excuse police actions', *The Guardian*, 18 August, 2005.

HM Chief Inspector of Prisons (1999) *Suicide is Everyone's Concern: A Thematic Review,* London, The Home Office.

Home Office (1999) Circular 30/99: *Post mortem examinations and the early release of bodies,* London, Home Office.

Home Office (1999) Circular No 46/1999: *Coroner Service: Model Coroners' Charter*, London, Home Office.

Home Office (2003) *The Report of a Fundamental Review: Death Certification and Investigation in England, Wales and Northern Ireland,* London, The Stationery Office.

Home Office (1999) *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny,* London, The Stationery Office.

Home Office (2002) *When Sudden Death Occurs*, London, Home Office.

House of Commons (2006) *Report of the Zahid Mubarek Inquiry Vol I,* London, The Stationery Office.

House of Commons Constitutional Affairs Committee (2006) *Reform of the coroners'system and death certification Eighth Report of Session 2005–06 Volume II Oral and written evidence 2006*, London, The Stationery Office.

House of Lords House of Commons Joint Committee on Human Rights (2004) *Deaths in Custody Interim Report: First Report of Session 2003-04,* London, The Stationery Office.

House of Lords House of Commons Joint Committee on Human Rights (2004) *Deaths in Custody Interim Report: First Report of Session 2003-04 Vol I*, London, The Stationery Office.

House of Lords House of Commons Joint Committee on Human Rights (2004) *Deaths in Custody: Third Report of Session 2004-05 Vol II,* London, The Stationery Office.

House of Lords House of Commons Joint Committee on Human Rights (2005) *Government Response to the Third Report from the Committee: Deaths in Custody: Eleventh Report of Session 2004-05,* London, The Stationery Office.

INQUEST (2007, forthcoming) *Dying on the Inside: examining women's deaths in prison custody,* London, INQUEST.

INQUEST (2004) *INQUEST's further evidence to the Joint Committee on Human Rights September 2004: Deaths in Custody – The Current Issues*, London, INQUEST.

INQUEST (forthcoming) *Narrative verdicts – an analysis of the impact of the Middleton judgment,* London, INQUEST.

INQUEST (2006) *Why Are Children Dying In Custody?*, London, INQUEST.

INQUEST/INQUEST Lawyers Group/Police Actions Lawyers Group (2006) *Fatal Shootings by police and the death of Jean Charles de Menezes,* London, INQUEST.

INQUEST/Liberty/Bhatt Murphy (2002) *Response to Consultation Paper on Attorney General's Review of the Role and Practices of The CPS in Cases of Deaths in Custody*, London, Liberty.

Independent Police Complaints Commission (2005) *Making the new police complaints system work better – Statutory Guidance*, London, IPCC.

Independent Police Complaints Commission (2005) *Step by step: advice for friends and family,* London, IPCC .

Liberty (2003) *Deaths in Custody: Redress and Remedies*, London, The Civil Liberties Trust.

O'Connor, P., QC (2004) 'Amin: The Legal Significance' in *Inquest Law* issue 6, London, INQUEST.

Parliament of Victoria Law Reform Committee (2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne, Government Printer.

Paterson, A. (2006) *In the Aftermath: the support needs of people bereaved by homicide*, London, Victim Support.

Prisons and Probation Ombudsman for England and Wales (2004) 'Memorandum from Prisons and Probation Ombudsman for England and Wales', written evidence to the House of Lords House of Commons Joint Committee on Human Rights *Deaths in Custody Interim Report: First Report of Session 2003-04*, Ev 67-68, London, The Stationery Office.

Retained Organs Commission (2002) *Report of an Independent Investigation into Organ Retention at Central Manchester and Manchester Children's University Hospitals Trust*, London, Retained Organs Commission.

Rolston, B. (2000) *Unfinished Business: State Killings and the Quest for Truth,* Belfast, Beyond the Pale Publications.

Royal Commission into Aboriginal Deaths in Custody (1991) *National report, Vol 1,* Canberra, Australian Government Publishing Service.

Ryan, M. and Sim, J. (2007, forthcoming) 'Campaigning For and Campaigning Against Prisons: Excavating and Re-affirming the Case for Prison Abolition' in Jewkes Y. (ed.) *Handbook on Prisons*, London, Willan.

Rynearson, E. (1987) 'Psychological Adjustment to Unnatural Dying', in S. Zisook, (ed.), *Biopsychosocial Aspects of Bereavement*, pp75-94, Washington, American Psychiatric Press.

Scraton, P. (1999) *Hillsborough: the Truth*, Edinburgh, Mainstream.

Scraton, P. (2002) 'Lost Lives, Hidden Voices: "Truth" and Controversial Deaths' in *Race & Class* 44, No 1, pp107-118, London, Sage.

Scraton, P. and Chadwick, K. (1987) *In the Arms of the Law: Coroners' Inquests and Deaths in Custody,* London, Pluto Press.

Scraton, P., Jemphry, A, and Coleman, S. (1995) *No Last Rights: The Denial of Justice and the Promotion of Myth in the Aftermath of the Hillsborough Disaster*, Liverpool, Alden Press.

Selby, H. (ed.) (1998) *The Inquest Handbook*, Sydney, The Federation Press.

The Shipman Inquiry (2003) *Death certification and the investigation of deaths by coroners, Command paper* CM 5854, London, The Stationery Office.

Thomas, L., Friedman, D. and Christian, L. (2002) *Inquests: a practitioner's guide*, London, Legal Action Group.

Also available from INQUEST

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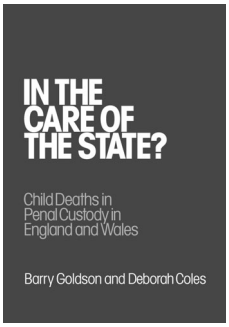

IN THE CARE OF THE STATE?

Child Deaths in Penal Custody in England and Wales

by Barry Goldson and Deborah Coles

£15.00
Paperback
160 pages
Published July 2005
ISBN 0 9468 5819 5

"This is a splendid book… and I entirely endorse the recommendations made" Lord David Ramsbotham, former Chief Inspector of Prisons

"This is not a comfortable read but an important one for all youth panel members and others taking decisions about offending children." *Magistrate* magazine, May 2006

"It benefits from collaboration between an academic and a practitioner with the result that it is accessible to a range of audiences without compromising on depth of analysis… it is the detailed analysis…that is particularly compelling, especially the case studies that serve to illustrate both the individual circumstances of the young people who, in most cases, took their lives whiles in custody….This is an interesting, thought provoking book that addresses an important and hitherto little explored issue." Professor Gill McIvor, Department of Applied Social Science, University of Stirling in *Youth Justice* Vol. 6, No 3 2006

In the Care of the State? provides the first detailed analysis of child deaths in penal custody. Thoroughly researched and extensively referenced, the book:

- Explains the background, the principal objectives and the primary research methods that underpin it.
- Traces the key shifts in contemporary youth justice law and policy that have produced substantial penal expansion and considers the consequences of such developments for child prisoners.
- Examines in detail child deaths in penal custody alongside a critical analysis of the responses to such deaths by key state agencies.
- Analyses the post-death investigation and inquest processes activated when a child dies in penal custody.
- Presents key conclusions and recommendations that, taken together, make a case for: the abolition of prison custody for children; a comprehensive review of child deaths in penal custody; the creation of an independent Standing Commission on Custodial Deaths and a full public inquiry into the death of 16 year old Joseph Scholes who died in prison in 2002.

In the Care of the State? is essential reading for academics, researchers, students, policy makers, penal reformers, youth justice agencies, child welfare professionals, children's human rights specialists, legal professionals and all others with an interest in the controversial subject of child imprisonment.

Barry Goldson is professor of sociology at the University of Liverpool.
Deborah Coles is co-director of INQUEST.

Inquest Charitable Trust (known as INQUEST) provides a specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, MPs and the wider public on contentious deaths and their investigation and on all aspects of the inquest system. INQUEST was established in 1981 following a number of controversial deaths in police and prison custody. Deaths in custody remain the main focus of INQUEST's work.

INQUEST has a free information pack for any bereaved family that explains the inquest process and where to find emotional and practical support. The organisation provides an in-depth casework service to the families of people who have died in police custody or following contact with the police or pursuit; in prison; in secure training centres; and in immigration and psychiatric detention. The focus on deaths in custody and the monitoring of such deaths means that the organisation is at the forefront of uncovering patterns and trends in this area.

Through its casework and monitoring the organisation develops policy proposals and undertakes research to lobby for changes to the inquest and investigation process; works with and on behalf of bereaved families and their legal representatives for changes in practice to reduce the number of custodial deaths; and to improve the treatment and care of those within the institutions where the deaths occur.

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